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ABSTRACT

This trainer manual is designed to assist facilitators in the design of entry-level courses and programs for substance abuse prevention specialists. The manual initially concentrates on a basic, generic approach to community work, and introduces the knowledge and skills needed to implement substance abuse prevention programs by using the community and its subsystems. Course goals and objectives are reviewed in the introduction. The notes to the facilitator emphasize group facilitation skills, flexibility, and an understanding of the specific needs of minorities and rural populations. The nine training modules are detailed in terms of goals, objectives, required materials, exercises, and activities. Worksheets, supplementary materials, and references are also given. The course materials focus on prevention strategies, knowledge of the community, the development of community support, implementation techniques, and burnout. The course pre-/post-test is provided at the conclusion of this manual. (NRB)

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TRAINER MANUAL

COMMUNITY-BASED PREVENTION SPECIALIST

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FOR TRAINING
AND RESOURCE DEVELOPMENT**

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ON DRUG ABUSE**

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*ALCOHOL, DRUG ABUSE,
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TRAINER MANUAL

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INTRODUCTION

Rationale and Description

This Community-Based Prevention Specialist training package represents a revision of the original course, of the same name, developed in 1977 by Shakura A. Sabur of the Southwest Regional Support Center.

The revised course reflects additional resources in prevention needs assessment, planning, and evaluation developed in the interim, as well as new perspectives on multicultural drug abuse prevention programming. Like its predecessor, the revised Community-Based Prevention Specialist course is designed as an "entry-level" course for any individual designated as the prevention specialist within his or her agency.

The Community-Based Prevention Specialist course is based on the synthesis of the theoretical propositions of Murray Ross (1955), Jack Rothman (1964), and Roland Warren (1966). This generic approach to community organization and community development considers:

- The nature of community
- The various institutional and organizational subsystems that make up a "community"
- Sociopolitical aspects of community life
- The nature and processes of institutional and organizational cooperation in community life, including:
    - Social structure
    - Social processes
    - Boundaries
    - Interface
    - Access
- The processes of intergroup and inter-organizational cooperation
- Roles and responsibilities of the professional in community organization and community work.

After this basic, generic approach to community work has been presented, the course introduces the special knowledge and skills required for understanding and implementing prevention programs, using the community and its diverse subsystems. The subsystems of reference are: the family, schools, religious organizations, social organizations, work organizations, and social welfare organizations, as well as other institutional or organizational subsystems that might be found within the community.

The course is based on the view that planning and implementing any programming activity in prevention, particularly in the area of drug and substance abuse, requires an understanding of the contexts and conditions that are associated with use of drugs and other substances. However, the body of knowledge about prevention of drug abuse is in its early developmental stage, and previous research projects have emphasized attempts to identify early indicators of potential drug and other substance abuse. These attempts have been focused primarily on the attributes of individuals or instances of behavior that were thought to be associated with drug and other substance use/abuse. Programmatic activities were typically designed to change attitudes, behaviors, or both.

An alternative, although not necessarily competing, point of view has guided the development of this community-based prevention program. This point of view incorporates the widely held assumption that a significant proportion of drug and other substance abuse is associated with differentials in opportunity to "the quality of life" in a given community. Further, it is assumed that a program characterized by the system-wide (community) definition of a problem, careful planning to address the problem, and opportunities for collaboration in attempts to solve the problem will have a high potential for success. When aspects of community life contribute to problems such as drug abuse, those aspects can be identified in a community assessment process and can then be addressed in an overall prevention strategy.

As NDACTRD's Cross Cultural Adaptation Task Force commented, "Primary prevention for racial/ethnic minorities must include a focus on empowering communities so that the health of their members will be improved. This concept indicates that political and economic issues, as well as personal and social ones, are appropriate subjects for prevention efforts."

The Community-Based Prevention Specialist program leaves the determination of whether a prevention program focused on individual-change or community-change is appropriate for a given community preventor. But, in recognizing that any program must become an integral part of the life of the community in order to succeed, survive, and grow, Community-Based Prevention Specialist seeks to allow community preventors to make their own program choices and also to provide them with critical skills for converting those choices into reality.

Goals

The overall goal of this course is to provide individuals charged with the responsibility of developing drug abuse prevention activities within their communities with the knowledge and skills necessary to successfully implement such activities. To this end, the course will provide participants with opportunities to gain an understanding of:

- Current drug abuse prevention programs, strategies, and philosophy
- The activities and approaches of NIDA's Prevention Branch
- Resource identification and utilization within the contexts of their own communities
- Needs assessment, planning, and evaluation of drug abuse programs
- National resources and technical assistance opportunities
- Their roles as drug abuse preventors
- Future directions in drug abuse prevention.

The course is also designed to develop and enhance participant skills in:

- Interpersonal communication
- Community organization
- Values clarification
- Action planning
- Creative problem-solving
- Public relations
- Decision-making
- Resource identification and procurement.

Objectives

At the end of this course, participants will be able to:

- Describe at least five personal strengths and skills that they possess
- List three of their own personal beliefs that shape their attitudes about drug abuse prevention
- Identify the four major components of NIDA's prevention continuum
- Write a one-sentence statement delineating their personal drug abuse prevention philosophy
- Identify at least one current prevention strategy for each component of NIDA's prevention continuum
- Identify the major target areas for drug abuse prevention programs
- List at least five existing prevention programs, and describe their general approaches
- List at least three prevention approaches that are consistent with their individual prevention philosophy
- Identify six indicators of "high risk" for adolescent drug abuse
- List at least five of the critical factors that they will consider in developing a drug abuse prevention program for their community
- List the major interest groups in their community
- Develop a profile of their community strengths, resources, and values

- List five factors that promote the acceptance of drug abuse prevention programs in their communities
- List five factors that hinder prevention efforts in their communities
- Write an action plan for creating community support
- List at least three criteria for success in their efforts to build community support for prevention
- Identify the constituent elements of an effective community media campaign
- List the significant communications media in their own communities
- Develop a plan for a media campaign or "drug abuse prevention week" effort
- Identify at least five program planning and development skills they utilized during the training
- Explain the basic concepts of networking
- List at least five community and five external resources that can help them develop effective prevention programs
- Identify at least three personal coping strategies they can utilize for personal growth
- List at least five interpersonal skills practiced during the training
- Take an inventory of the community information and planning methods generated during the training.

Notes to the Trainer

A. Desired Training Team

Given the strong emphasis in the course on "hands on" experience, action planning, and group process, the trainers will be required to have outstanding skills in group facilitation. Ideally, the course will be offered by a three-person training team including at least one trainer who has had actual (preferably extensive) experience working in communities. Wherever possible, an experienced prevention professional should be a training team member. Formally involving the State Prevention Coordinator in the training process will also ensure the practical application of the training, particularly in the areas of resource identification, networking, and evaluation.

B. Creativity and Flexibility

In keeping with the field of prevention, this revised course is intended to be open-ended and evocative. You are encouraged to use your own experience and imagination to tailor the materials to your perceptions of your training population and your own wisdom about doing prevention in communities. The designers have attempted to provide you with options and stimuli, not to restrict you to a lifeless design.

C. Cross Cultural and Rural Issues

Trainer's "Notes" throughout this course attempt to reinforce our intention to address the specific needs and concerns of ethnic and racial minorities and rural populations. As NDACTRD's Cross Cultural Adaptation Task Force commented about the existing prevention courses, "Primary prevention for racial/ethnic minorities must include a focus on empowering communities so that the health of their members will improve. This concept indicates that political and economic issues, as well as personal and social ones, are appropriate subjects for prevention efforts."* In addition, the Task Force outlined the specific training considerations that need to be considered in creating an effective learning environment for individuals from racial and ethnic cultures. These include: communication issues (language, space/distance questions, culture-specific verbal and nonverbal cues, values assumptions of the trainer); trainer behaviors (attitudes, interventions, self-awareness, lack of cultural bias); group dynamics (differences in homogeneous or heterogeneous populations, differing cultural norms on appropriate group behaviors); learning styles (dependence on print media, level of training and educational experience, acceptance of alternative learning styles); power, authority and influence (styles of leadership, individualism vs. collectivism biases); sex roles, relationships, and identities (the interplay of male/female issues and racial/ethnic issues); and socioeconomic, political, and legal influences (nationionalism, legal issues, generic community transformation issues). The challenge to the trainer, then, is to critically examine every component of the training experience--his or her behavior, the manuals and exercises, the information and examples presented, the logistics of the training--to ensure an optimal learning opportunity for every participant.

Course Prerequisites

Two NDACTRD training courses will facilitate effective utilization of this training experience; Drugs in Perspective and Adolescence: Intervention Strategies provide complementary information and perspectives. Also, the National Institute on Mental Health's Social Seminar Series is a valuable primer on human development and positive approaches to mental health--ideas that underlie much of prevention programming today. Finally, the most important prerequisite is a real desire to embark upon a positive prevention effort within your own community--the commitment to try what's learned in training is critical to the program's success.

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*Cross Cultural Adaptation Task Force, Summary Report, National Drug Abuse Center for Training and Resource Development, Washington, D.C. 20015, 1979.

MODULE I

MODULE I: INTRODUCTION AND OVERVIEW **TIME:** 3 HOURS 15 MINUTES

GOALS

- Introduce participants and trainers to each other
- Examine individuals' expectations about the course, in terms of design and content
- Share individual strengths and successes.

OBJECTIVES

At the end of this module, participants will be able to:

- Identify the names and organizational affiliations of at least three other participants and all of the trainers in the course
- List at least three personal strengths and skills that they possess
- Identify the major goal and describe the general sequence of activities of the course.

MATERIALS

- Registrations Forms
- Pretest Forms
- Pencils
- Newsprint
- Magic markers
- Worksheets: "Strengths and Expectations," "Roles and Responsibilities"

MODULE 1	OVERVIEW	
EXERCISE	TIME	METHODOLOGY
1. REGISTRATION	30 MINUTES	INDIVIDUAL
2. PRETEST	30 MINUTES	INDIVIDUAL
3. TRAINER INTRODUCTIONS	5 MINUTES	TRAINERS
4. NAME GAME	25 MINUTES	LARGE-GROUP EXERCISE
5. GROUP CONTRACT	15 MINUTES	DISCUSSION
6. HOW WE GOT HERE	30 MINUTES	SMALL-GROUP EXERCISE
7. PERSONALIZING THE DATA	30 MINUTES	SMALL-GROUP EXERCISE
8. COURSE OVERVIEW	20 MINUTES	LECTURE
9. SUMMARY	10 MINUTES	LECTURE

MODULE I: INTRODUCTION AND OVERVIEW

TIME, MEDIA, AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
30 MINUTES Registration Forms Pencils Coffee and Tea	1. REGISTRATION NOTE: Registration should take place 30 minutes before the pretest is delivered. • Greet participants as they arrive. • Ask each participant to complete and return the registration form. • Suggest that participants help themselves to coffee or tea if they wish.
30 MINUTES Pretest Forms	2. ADMINISTER THE PRETEST • Explain why the pretest and post-test are given. NOTE: When administering the pretest, inquiries about test items should not be answered. It should be explained that the course will enable participants to understand what responses are correct and, more important, why these responses are correct. Emphasize that after post-testing, participants will be free to discuss any and all of the items on either the pretest or the post-test. • Read the pretest instructions, and answer any questions. • Ask trainees to complete the pretest individually and return the pretest forms to you.
5 MINUTES	3. TRAINER INTRODUCTIONS • Explain that Module I deals with housekeeping issues: learning who's who, how the trainers plan to conduct themselves over the next five days, and what both trainers and participants can expect from this course. • Introduce the trainers, describing their roles. • RSC trainers also may wish to give a brief overview of the National Training System, identifying each of the five RSCs on a hand-drawn U.S. map and the States that are allocated to

their region. Also stress the importance of the State and regional prevention coordinators (SPC and RPC programs; see diagram, Figure I-1, p. 18).

- include in your overview of the Prevention Branch and its affiliated projects the following information:
  - The focus of NIDA's Prevention Branch is a research/demonstration thrust designed to insure evaluation of whatever prevention services are provided, and now concentrates upon: (1) the acquisition of new knowledge, (2) dissemination of knowledge models and strategies, and (3) the development of the capacity of States and local communities to effectively deliver drug abuse prevention services.
  - The Prevention Branch's technical assistance resource sharing network is called Project Pyramid. This Branch effort serves to collect and categorize knowledge relevant to drug abuse prevention and to disseminate it by telephone, on-site visits, and in written form so that consumers of the service discover what is known in such areas as alternative projects, community development models, peer counseling, prevention of misuse of drugs by the elderly, and the effects of drugs in school curriculum projects. Where on-site consultation is needed, arrangements are made by the Branch. Such services are easily accessible through a toll-free number.
  - CMA (The Center for Multicultural Awareness) is also a technical assistance resource sharing project, which emphasizes strategies and programming with clear emphasis on multicultural needs by ethnics of color. Its focus is State agencies for drug abuse (SSA's), telephone communication, written information, on-site technical assistance, and program strategy, all of which are available through this program.

TIME, MEDIA, AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
	- NPERN (The National Prevention Evaluation Resource Network) is an evaluation and related information/dissemination system being developed for nationwide use. It has completed a pilot phase in six States. - Addresses and telephone numbers for these services are listed in "A Basic Prevention Library," on p. 271 of the Participant Manual.
25 MINUTES "A Word About: Climate Setting" "Some Other Ice-Breaker Activities"	4. STRUCTURED EXPERIENCE: THE NAME GAME

NOTE: Feel free to substitute for the Name Game any icebreaker exercise that serves the purpose of introducing all of the participants. See "A Word About: Climate Setting" and "Some Other ice-Breaker Activities."

- Explain the Name Game.

Script:

The purpose of the Name Game is to introduce everyone. You will be asked to say your name with a one-word adjective beginning with the first letter of your name after repeating the names and adjectives of the persons preceding you. This process is continued around the circle until it reaches the trainer who introduced the game. The trainer ends the exercise after he or she recites the adjectives and names of all the participants.

Example:

Trainer A: Hello, I am Patient Paula.

Trainee l: Hello, Patient Paula, I'm Nervous Ned.

Trainee 2: Hello, Patient Paula, Nervous Ned, I'm Confident Connie.

Trainee 3: Hello, Patient Paula, Nervous Ned, Confident Connie, I'm Curious Charlie.

- Participate in the Name Game.

15 MINUTES

Newsprint
Magic Markers

5. GROUP CONTRACT

NOTE: Ground rules may be written on newsprint for clear visibility.

- Specify ground rules. Some ground rules you might consider are:
  - Training sessions will begin on time.
  - Each participant can learn from and share with others.
  - Differing points of view can be explored in a nonjudgmental way.
  - If you have questions, or if something seems to be unclear, feel free to discuss these any time.
  - There are no scheduled breaks, per se. Each participant will be responsible for taking care of his or her own needs, at will. Trainers and participants can feel free to suggest group breaks, when appropriate.
  - At the end of each day, the last half hour will be devoted to sharing feedback about the training.
  - This contract is negotiable and can be renegotiated at any time.
- Discuss logistics (breaks, location of restrooms, coffee, parking, etc.).

NOTE: Experiences and Expectations. The exercises in the remainder of this module allow participants to begin sharing their backgrounds and experiences with other trainees. These will help them to clarify their expectations of the training, in light of the training design of the course.

MODULE I: INTRODUCTION AND OVERVIEW

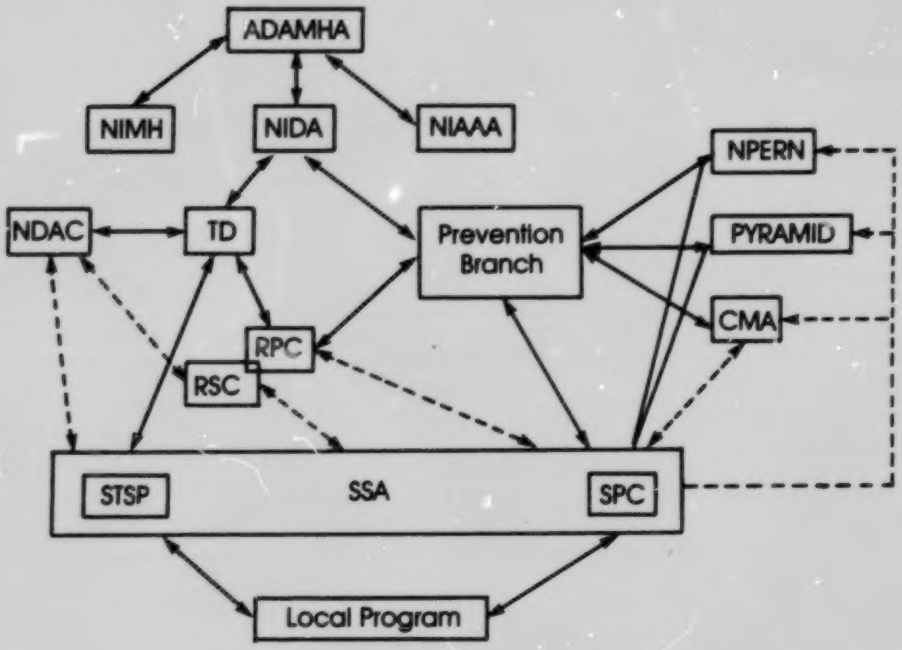
TIME, MEDIA, AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
30 MINUTES	6. EXERCISE: HOW WE GOT HERE
	• Individuals will self-select into small groups of 5-6 people (trainers should encourage participants not to group themselves with friends or colleagues; rather, they should select individuals whom they have not yet met).
"Roles and Responsibilities" Worksheet	• In each small group, one individual will assume the role of recorder and, on the worksheets provided (Worksheet I-1, p. 19), compile the following information on group members: NAME PROGRAM ROLE RESPONSIBILITIES
	NOTE: Trainer should make note of any individuals who represent rural or ethnic programs.
	• Another group member will be selected (by the group) to act as reporter. He/she will be responsible for sharing the information with the re-assembled large group.
Newsprint	• In the large group, the reporters are asked to discuss the composition of the small groups, including: - What kinds of programs are represented here? - What positions (levels) are represented? - What are some of the other characteristics of the programs with which trainees are affiliated? (e.g., special populations, size of programs, length of time in operation).
	• Trainer tabulates the data on participants, drawing attention to the similarities and differences within the training population, including: - The diversity of experiences, and differences among program approaches represented

TIME, MEDIA, AND MATERIALS	*OUTLINE OF TRAINING ACTIVITIES*
	- Differences in cultural and geographic orientation.
30 MINUTES "Strengths and Expectations"	7. PERSONALIZING THE DATA • Trainer now asks individuals to complete the worksheet called "Strengths/Expectations" (Worksheet I-2, p. 20), listing five of their own expectations of the course and the personal strengths or skills that they bring to the training. The trainers might choose to complete and discuss their own worksheets as examples. An example of a participant skill would be: ability to work in rural areas with youth.
Newsprint	• Participants should now re-form into the small groups they had formed before and tell each other about the information on the worksheets. A new recorder will compile lists of strengths and expectations on newsprint. • In the large group, a second reporter will discuss and summarize the expectations and strengths of the members of his/her small group.
20 MINUTES Course Outline	8. COURSE OVERVIEW Trainer will then introduce the goals and structure of this training, in light of the expectations that have surfaced during the previous exercise. As the nine modules are previewed, the trainer should note which expectations on the newsprint lists will probably be met during the structured training and which will not be met. Attention should also be given to alternative ways of helping participants meet their needs. For example, the individual strengths participants have listed might lead to linking one person with a particular skill in a substantive area to another person with a need to know more about the area. NOTE: A pick-up list might be a useful tool in this process. Using a sheet of newsprint, list all of the participant expectations that will not be directly addressed in the course of the training. Explain that

TIME, MEDIA, AND MATERIALS	*OUTLINE OF TRAINING ACTIVITIES*
	informal techniques for addressing those expectations, or indirect relationships between course content and participant expectations, will aid in addressing the expectations on the pick-up list. In addition, individuals are encouraged to propose creative strategies to help meet their own needs within the context of the training.
10 MINUTES	9. SUMMARY ● Trainer will now summarize the module, stressing the amount of information generated about the individuals in the training and the prevention programs they represent. Points of emphasis should include: - The learning opportunities presented by the experiential, program, cultural, and geographic diversity among the training group - The individual strengths and skills that trainees bring to this experience - The responsiblity of the trainee to ensure that the training meets his/her expectations.
	END OF MODULE I ● Participant reading assignment NOTE: At the end of each module, ask trainees to familiarize themselves with the resource material to be covered in the next module. It is understood that the breaks between the morning and afternoon sessions do not provide enough time for thorough studying of the material.

Figure I-1

Scheme of the Division of Training and Prevention Branch Programs


ADAMHA
NIMH
NIDA
NIAAA
NPERN
NDAC
TD
Prevention Branch
PYRAMID
CMA
RPC
RSC
STSP
SSA
SPC
Local Program

NOTE: NIAAA funding structures vary from state to state. In some states, NIAAA programs are funded through a separate system, similar to the one depicted here. In others, NIAAA and NIDA programs are both funded through the single system shown here.

ROLES AND RESPONSIBILITIES

NAME	PROGRAM	ROLES	RESPONSIBILITIES
1.			
2.			
3.			
4.			
5.			
6.			
7.			

STRENGTHS/EXPECTATIONS

STRENGTHS	EXPECTATIONS
1.	
2.	
3.	
4.	
5.	

INSTRUCTIONS

In the left column, write down five expectations you have about this course--what you might like to see happen, specific things you would like to leave the training with, what you think you came for. To think more reflectively about your expectations, you might complete the sentence, "I'll be really satisfied when I leave this course if. . ."

In the right column, list five strengths or skills you bring to this training. These may be prevention-specific (I'm good at values clarification), or organizational (I'm really good at budgets), or personal (I'm a good listener). Think about how a friend or colleague might complete the sentence, "What I really like about you is. . ."

SOME OTHER ICE BREAKER ACTIVITIES

The activities suggested below are generally helpful in at least three ways--

- As ice-breakers
- Aids for the participants to get to know one another
- Help in identifying group members as possible future resources.

And, besides, these activities are fun. This list is just a beginning, and the length of your own list will grow with your experiences.

1. Pair Introductions

   Each persons meets and gets to know one other person and in turn introduces his or her partner to the entire group.

2. Dyad and Quartet

   Same as above, but instead of introducing his partner to the entire group, he or she introduces him or her to another dyad.

3. One-Minute Autobiography

   Break into groups of a dozen or so. Each person is given one minute to tell about himself. Use a timekeeper, and don't let anyone go over one minute. Restrictions can be set as to what can be talked about (e.g., nothing about job, family, home town, hobbies). These restrictions enable the participants to get right to attitudes and values.

4. Depth Unfolding Process

   Use this activity in small groups, because it takes five minutes per person. In the first three minutes, tell what has brought you to this point in your life. One minute is used to describe your happiest moment. The last minute is used to answer questions from others. The leader discloses first, to aid in trainee comfort.

5. Structured Introductions

   In dyads, small groups, or in the large group, participants can talk about their happiest moments, write their own epitaphs, write a press release about themselves, etc.

6. Life Map

   Each person draws on newsprint with crayons or magic markers a picture of his life, using stick figures and symbols.

7. Name Circle

Participants sit in a large circle. The leader begins by stating the name of the person seated to his right, followed by his own name. The person to his right repeats the leader's name, his own name, and adds the name of the person seated to his right. This process is repeated around the entire circle.

8. Sandwich Boards

Each person writes on a sheet of newsprint "Things I Know" (about the content and purposes of the training, areas of personal expertise, etc.). On a second sheet of newsprint, he writes "Things I Want to Know." The sheets are joined with tape, sandwich board style, and the participants mill round, nonverbally, identifying resources and getting to know one another.

9. Consensus-Based Group Objectives

Each person privately lists five (the number is optional) personal objectives for the training. He or she shares them with a partner, and they arrive at five. The dyads go to quartets and then to octets. The octets report out their objectives (reached by consensus), and a total-group set of objectives is formulated. This activity can aid in checking the contract and also help obviate the problem of hidden agendas.

10. Sentence Completions

A prepared list of sentences (e.g., "Anyone who smokes in front of his children...") is spun around the group or used in small groups.

A WORD ABOUT: CLIMATE SETTING*

In participatory training, the group atmosphere should encourage honesty and openness. Success depends upon everyone feeling free to actively participate, to comment, to question, to give feedback. Actively listening to others is as important as actively participating in the group. This atmosphere is often referred to as the training "climate."

The training design for Module I is structured to establish a climate conducive to learning through the Name Game structured experience and the Community Reporter expectation exercise.

Immediately after the pretest is concluded and the trainers have introduced themselves, the session opens with the Name Game. This is a fun way of helping participants begin to get acquainted and to feel at ease with each other. It provides each participant with a low-risk experience in speaking to the entire group and establishes an atmosphere in which learning (in this case, people's names) can be an enjoyable process.

The Strengths/Expectations exercise is a structured way of helping participants learn more about each other. It helps participants begin to build relationships with each other by dividing the large group into smaller groups. It facilitates the involvement of individuals in a newly formed group and it allows participants to become acquainted quickly in a relatively nonthreatening way. It also promotes a compatible climate and readiness for interaction within a group through the sharing of personal information.

In the Strengths/Expectations exercise, participants identify some of their expectations about the course. You then use this data to discuss which expectations can and cannot be met through this course. This structured experience helps trainees begin to answer the questions: Who are the other people in this course? What are they like? How are we similar? How are we different?

---

*Adapted from Ann R. Bauman, "Introduction to Learning Theory: The Learner." Training of Trainers--Trainers Manual, Rosslyn, Virginia: NDAC, 1977, p. I-15.

MODULE II

MODULE II: PERSPECTIVES ON PREVENTION

TIME: 3 HOURS

GOALS

- Acquaint participants with the history of drug abuse prevention, current governmental definitions of prevention, and the social and environmental influences on drug use in our society
- Aid participants in discovering their own attitudes and concepts about drug abuse prevention.

OBJECTIVES

At the end of this module, participants will be able to:

- List at least five social and cultural factors that influence individual drug consumption choices and patterns
- Identify two statements that reflect their own concept of drug abuse prevention
- Identify the prevention definitions currently used by NIDA and other Federal agencies active in drug abuse prevention
- List three major historical events involved in the development of the drug abuse prevention movement in this country.

MATERIALS

- Newsprint
- Magic Markers
- Definitions of Prevention
- Selected Readings

MODULE II

OVERVIEW

EXERCISE	TIME	METHODOLOGY
1. INTRODUCTION/OVERVIEW	5 MINUTES	LECTURE
2. TO TELL THE TRUTH	45 MINUTES	SMALL-GROUP EXERCISE
3. INFLUENCING FACTORS	20 MINUTES	SMALL-GROUP EXERCISE
4. EXAMINING THE DRUG CLIMATE	30 MINUTES	LECTURE/DISCUSSION
5. HISTORY OF DRUG ABUSE PREVENTION	25 MINUTES	LECTURE/DISCUSSION
6. THE CONCEPT OF PREVENTION	15 MINUTES	LECTURE/DISCUSSION
7. DEFINITIONS OF PREVENTION	30 MINUTES	LARGE-GROUP EXERCISE
8. REVIEW/PREVIEW	10 MINUTES	DISCUSSION

MODULE II: PERSPECTIVES ON PREVENTION

TIME, MEDIA, AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
5 MINUTES	1. INTRODUCTION/OVERVIEW • The trainer previews this module, in which participants will have the opportunity to examine their beliefs about drug abuse prevention definitions currently in use by various Federal, State, and local agencies.
45 MINUTES	2. SMALL-GROUP EXERCISE: "TO TELL THE TRUTH" • Participants form three small groups; individuals are asked to develop three statements that reflect their personal concept of drug abuse prevention. TWO OF THE SENTENCES SHOULD BE TRUE, i.e., accurately reflect their personal beliefs. ONE SENTENCE SHOULD BE FALSE, i.e., be contradictory to their personal prevention philosophy. Examples of these statements might be: 1. It's okay for a preventor to use drugs. 2. Drug education programs should teach youth how to use drugs wisely. 3. Alcohol should be the primary focus of prevention programs. 4. Peer groups determine the success or failure of a prevention program. 5. Alternative prevention programs are effective only with highly motivated youths. 6. The only reason people resort to drug use is because it's available. 7. "First the person takes the drug; then the drug takes the person" (an old Japanese proverb). 8. Prevention clients already have experimented with drugs, so there is nothing to prevent. 9. Prevention programs do not need to focus on self-concepts.

TIME, MEDIA, AND MATERIALS | **OUTLINE OF TRAINING ACTIVITIES**

- Each small-group member, in turn, is asked to recite his/her three sentences. The other members of the group are asked to decide which of the three sentences was the false statement; the speaker then informs the group of their accuracy in identifying the false statement.

NOTE: Throughout the course, participants are divided into three small groups. One trainer should assume facilitative or advisory responsibility for each small group, be attentive to questions and issues raised, and give any necessary technical assistance.

- Trainer re-convenes the large group, lists true statements on newsprint, and discusses the exercise. Discussion points should begin to elicit:
  - Any difficulties participants had in developing prevention statements, either accurate or inaccurate
  - Did individuals have difficulty identifying the false statements of other group members?
  - Is a spectrum of prevention philosophies present in the training population?
  - What underlying assumptions about the nature and emphasis of drug abuse prevention surfaced during the exercise?
  - Did the exercise reveal any cultural issues implicit in the participant's prevention philosophies?

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20 MINUTES

Newsprint

3. SMALL-GROUP EXERCISE: INFLUENCING FACTORS

- Re-assemble the small groups from the previous exercise. Ask each group to make a list of the factors which they feel influence their personal positions on drug abuse prevention. One individual will be chosen as the recorder, and will list the group's ideas on newsprint.

- Large-group discussion, in which the small groups report on their lists of influencing factors. The trainer should encourage further discussion around these factors, perhaps grouping them into categories as:
    - Cultural factors
    - Environmental factors
    - Program experience
    - Personal lifestyles
    - Others, including the ways in which rural and ethnic differences dictate differences in the selection of influencing factors.

30 MINUTES

4. LECTURE/DISCUSSION: EXAMINING THE DRUG CLIMATE

NOTE: This lecture can be shortened and incorporated into the discussion session that follows the small-group brainstorm, or used as supportive material to highlight points raised during the large-group discussion. Feel free to use your own discretion, based on your time constraints.

- Trainer discusses the variety of factors influencing the way we value and define drug use/abuse and, consequently, drug abuse prevention. A similar web of causes, correlates, and influences affects individual choices about whether to use chemical substances and guides our selection of appropriate prevention activities.
- Point out that the information is provided as additional data for further developing participants' awareness of the factors that influence the atmosphere in which they work as preventors.
- Encourage participants to ask questions or make comments throughout the lecture/discussion; alternately, questions and comments may be entertained after the lecture.

TIME, MEDIA, AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES

NOTE: The overview below is a suggested approach for reviewing drug merchandising and those medical and social pressures that contribute to wider drug use. It might be helpful simply to highlight the main points on a few sheets of newsprint, citing a few examples under each area.

Script:

"The real web of forces tugging individuals toward the American drugstore includes pressures and motivations that have flourished in almost every culture in history. Some of those forces have intensified in this century.

"Millions of adults have used at least one of three substances that most people do not think of as drugs, but that contain drugs by any scientific or medical definition: the nicotine in tobacco, the caffeine in coffee and cola in drinks, and alcohol. With and without doctors' prescriptions, millions more take narcotic cough syrups, stimulants, sedatives, and tranquilizers and think of them as medicine.

"All of the substances mentioned above are called psychoactive drugs because they change the minds or moods of the people who take them. Their effects vary widely from user to user and depend mostly on dosage, rate of consumption, the user's personality, and circumstances.

"Excessive or compulsive use of a drug to an extent that is hazardous to the user's health, to his social and vocational functioning, or to the rest of society, is termed drug abuse. Even licit drug-taking is sometimes ritualistic: lighting a cigarette after a meal or clinking wine glasses and saying 'cheers' before the first sip is as much a rite as passing a marijuana cigarette at a party. Most important, the accepted drugs can be just as dangerous as 'street,' or illicit, drugs--tobacco, alcohol, 'uppers,' 'downers,' even caffeine; people who use these drugs excessively thus become drug abusers.

Revolutions in Drug-Taking

"The real acceleration of psychoactive drug use in the U.S. and other industrialized countries came as chemists began to create synthetic substances and made their use acceptable.

"The first revolution concentrated on diseases of the body. It began with vaccines, concentrations of killed or weakened viruses or bacteria that force the body to produce natural antibodies to fight illnesses such as diphtheria, whooping cough, polio, and measles.

"Antibiotics, including penicillin, and the sulfa drugs that came into wide use during World War II made possible dramatic cures for scores of infectious diseases.

"The initial successes of vaccines and antibiotics underscored the old idea that drugs are beneficial for the body.

Tranquilizers, Barbiturates, and Stimulants

"In the early 1950's, a second pharmacological revolution brought about the development of drugs for treating disorders or diseases of the mind. The most dramatic of these are the tranquilizers, including Thorazine (the brand name of the drug known generically as chlorpromazine). Synthetic tranquilizers subdue patients suffering from the most serious kinds of mental illnesses--schizophrenia and manic-depressive psychoses--without necessarily putting the patients to sleep, as other calming agents can.

"Related to tranquilizers are the so-called 'downers,' chiefly barbiturates such as Nembutal, Seconal, Luminal, and Amytal (pento-, seco-, pheno-, and amobarbital). Discovered in the early 1900's, barbiturates have been used as sleeping pills and to control epileptic seizures.

"Two drugs that do seem to produce calm and have a lower addiction potential than barbiturates are Librium (chlordiazepoxide) and Valium (diazepam). These are currently among the most widely prescribed psychoactive drugs.

"Yet another component of the revolution in treating the mind with drugs was medical use of stimulants stronger than coffee and tea. Cocaine, a stimulant derived from leaves of coca plant, was used medically in the nineteenth century as a local anesthetic and occasionally as a 'cure' for alcoholism. In the 1920's doctors began prescribing a class of synthetic compounds called amphetamines, which were less expensive than cocaine, had fewer but still significant side effects, and could be given as pills.

Convenience Drugs

"Once tranquilizers and stimulants had made it acceptable to take drugs that act on the mind, a third pharmacological revolution expanded the medical use of drugs still further. The eight million American women using 'the pill' as a convenient contraceptive are not trying to cure physical illness, nor are they directly out to change their moods. With the pill, says psycho-pharmacologist Ray, 'We have moved from drugs to cure the body, through drugs to cure the mind, to drugs that alter the body for our convenience and pleasure' (Drugs, Society, and Human Behavior, p. 4). That, of course, is precisely why many people doctor themselve with drugs from alcohol to Valium.

"Another consequence of the pharmacological revolutions is that harried doctors have come to prescribe too many drugs too often, according to a growing number of critics. Often without fully realizing what they are doing, doctors find themselves making an 'educated guess' about an illness and writing a prescription in the hope that it will help or to show they are at least doing something. Patients seldom object; nurtured on sensational accounts of new drug cure-alls, most people have come to expect a prescription for what ails them.

Drug Merchandising

"As the number of drugs has increased, drug advertising has increased correspondingly. The alcohol and tobacco industries spend a total of $1 million daily pushing their products. The U.S. pharmaceutical industry now spends three to four times as much money on promotion as it does on research.

"One famous advertisement illustrates how ready-made reasons for using drugs have come to include mental as well as physical problems: 'For a headache, take aspirin. For tension, take Compoz.' Another ad encourages the common pattern of taking one drug to counteract the effects of another. From the midst of a party hubbub that suggests drinking is going on, a man burbles, 'If I happen to overdo it, isn't it nice there's Alka Seltzer?'

"Doctors are particularly vulnerable to drug company sales pitches, many critics charge. Hard pressed for time, doctors get much information about new drugs from the traveling 'detail men' the drug companies send out and from the ads in medical journals. Even the solemn-looking Physicians' Desk Reference to drugs in most doctors' offices is not impartial. Though the entries include warnings required by the FDA, they are written by drug companies, which pay $110.00 per column inch for the space.

Big Business

"The American drugstore is one of the nation's major industries. In the illegal drug market alone, customers spend at least $2 billion a year. That bill is about equal to the $2.5 billion that Americans spend on psychoactive pharmaceuticals obtained by prescription. Some $2.5 billion more goes for coffee, tea, and cocoa (which contains the stimulant theobromine), $12 billion for cigars and cigarettes, and a whopping $25 billion for alcohol.

Unbalanced Perceptions

"It is one thing for experts to present facts demonstrating that an alcohol beverage has a great deal in common with a marijuana cigarette; it is another to gain public acceptance of those facts. According to Don Samuels, a Miami drug-education coordinator, 'Often when we report to a parent that his kid isn't acting the way he should and smells of liquor the reaction is: Thank God! I thought he was on drugs.' (Time, April 22, 1974, p. 76.)

"Why the mental block? The long history of alcohol and tobacco use in the U.S. makes these drugs easily taken for granted. Youngsters who drink and smoke are adopting rather than rejecting their parents' values. The national effort to curb drinking by making the manufacture and sale of alcohol illegal (1920-1933) failed abysmally; in contrast to most street drugs, alcohol is legally sold to people eighteen and older in many states. Even the jargon related to alcohol has an approving ring: people speak of it as a 'beverage' or 'social lubricant' rather than a drug.

Unbalanced Policies

"Pigeonholing 'legal' and 'illegal' drugs in separate compartments often has contributed to ineffective social and political drug policies. In many ghetto areas, for example, community leaders and citizen groups have declared 'war' on heroin use, but they do nothing about the tobacco and alcohol that kill more people in ghettos than all other drugs put together. In the U.S., more private and public funds have been spent on research and cures for 1 million cancer victims than on the nation's 9 to 10 million alcoholics.

"In short, national attitudes and policies about drugs are schizophrenic. The situation was bitingly described in a recent article by researchers Methea Falco and John Pekkanen of the Drug Abuse Council, a foundation-funded group: 'We prohibit heroin, jail addicts, and employ thousands of agents to supress the illicit traffic; yet, we spend hundreds of millions of dollars to advertise alcohol, amphetamines, barbiturates, and tranquilizers--substances which can be far more injurious to individuals and society than heroin. We support harsh criminal penalties for heroin addicts because we are afraid of the street crimes they might commit.... Yet we tolerate thousands of automobile deaths each year due to drunken driving....' (Bergen N.J., Evening Record, September 15, 1974, p. D1).

Stress and Change

"In the twentieth century, the rapid development of new drugs is only one sign of an acceleration of new experiences for every group. Basic social institutions no longer seem to be as satisfying as they once were for the people in them--families break up, schools are filled with conflict, and government bureaucracies have become incompetent and inflexible. Jobs have become so repetitious and boring that numbers of Americans tell poll takers that they are deeply dissatisfied with their work. An increased amount of leisure time may be more frustrating than pleasurable. Free time may make some people happy, but it seems to be something of a burden to people who sit before the TV screeen seven hours a day or race from hobby to hobby to keep busy. Leisure can be particularly frustrating for poor people, who have the time to enjoy the easy life they see in ads but lack the money to afford it.

"For such pressures and more, readily available, highly promoted drugs have come to be accepted as a help. 'Drowning sorrows' in alcohol, of course, is the symbol of drugtaking to blot out pain. Using drugs such as LSD...may be an attempt to find inner meaning when the outer world seems meaningless.

High-Risk Populations

"Colleges are what sociologists call subcultures--segments of the larger society possessing distinctive norms, values, and patterns of behavior. Other American subcultures have shown high incidences of drug use. These include not only the Black, Puerto Rican, and Chicano communities, but also the Italian and Irish subcultures.

"Rapid social change, which increases drug taking in all groups, can be particularly hard on native and other tightly bound subcultures. American Indians and Eskimos have had some of the highest rates of alcoholism in the nation, for example.

"Noncollegiate subcultures also exert pressures to conform. For example, in one working-class white community studied by Harvey Feldman, young neighborhood leaders use heroin as a badge of power. Says Feldman: 'Their use... solidifies a view of them as bold, reckless, criminally deviant--all praiseworthy qualities from a street perspective' (Society, May/June 1973, p. 38).

Widespread Use

"Pharmaceutical psychoactive drugs are far more commonly used than black-market substances. At the low end of the use spectrum are LSD, nutmeg (a

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spice that is taken orally to induce a euphoric state), glue, and cocaine. An estimated 600,000 people are addicted to, or physically dependent on, heroin. Roughly 100,000 regularly use methadone, the legal heroin substitute available in treatment programs. In addition, hundreds of thousands of individuals take opium derivatives to relieve pain and coughs. More than 13 million people regularly smoke marijuana, and twice as many have tried it. Estimates derived from the Report of the National Commission on Marijuana and Drug Abuse indicate that perhaps 37 million people use sedatives such as barbiturates legally and illegally, over 63 million smoke tobacco, and 89 million drink alcoholic beverages.

"For engineers, production-line workers, athletes, and others, illegal drugs usually are additions to a 'basic' drug pattern that includes beer, coffee, and cigarettes. A survey for the Commission on Marijuana and Drug Abuse found that 86 percent of the adults who smoke marijuana also drink regularly and 58 percent use prescription psychoactive drugs; 33 percent of sedative users also take stimulants. To take up marijuana, then, is not to give up alcohol. Hence, the surge in drug use probably means that 'people are drugging more' and more people are drugging.

"Social scientists increasingly think that many drug-taking behavior patterns are learned from other people rather than determined by the qualities of the drug. Most of this social learning--known as socialization--goes on without formal teaching; it seeps in from brief hints dropped on playgrounds or jobs and from the examples set by parents.

"The physical changes that mark the end of childhood have come to the average child one year earlier every three decades for the past 115 years. Drug use among younger adolescents has increased concurrently, with the help of parental example, advertising, and peer pressure. Alcoholics Anonymous recently started special chapters for children, some of whom became 'alcoholics' as early as age 10.

"A number of social scientists recently have been trying to reverse the traditional question of why people use and abuse drugs. Instead, they ask, why do some people not use drugs, even when they are exposed to the intense American medical and social pressures favoring drug use?"

- (Fort & Cory, 1975)

- Ask for final questions and comments.

NOTE: Lecture and discussion should not occupy more than 30 minutes in total.

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25 MINUTES

5. LECTURE/DISCUSSION: HISTORY OF DRUG ABUSE PREVENTION

- Give a brief discussion of the history of drug abuse prevention efforts. Focus on social policy as expressed in legislation, on societal concerns about the dangers of drug abuse, and on the types of activities that characterized prevention efforts during various historical periods.
- Encourage participants to ask questions or make comments throughout the lecture/discussion; alternatively, questions and comments may be entertained after the lecture.

NOTE: The overview below is provided as a suggested approach to reviewing the history of drug abuse prevention efforts. Other ways to present this historical perspective might include (1) showing the NIDA film, "Getting in Focus," which is a compilation of drug abuse media spots over the last 10 years and (2) generating a group discussion.

Script:

Historical Overview of Drug Legislation

"In 1906, the Federal goverment responded to the patent medicine problem by passing the Pure Food and Drug Act which, among other things, required that the names and amounts of ingredients appear on the label of the product and that alcoholic content be no greater than 17 percent of the product. By 1914, Congress became sufficiently aware of perceived difficulties with the Pure Food and Drug Act, and the congressmen passed the Harrison Narcotic

Act, which imposed recordkeeping, reporting, and registration requirements for certain aspects of the drug trade, and which required possession and use of certain drugs to be legitimized with a special prescription.

"Following several Supreme Court decisions (e.g., Webb v. U.S. Supreme Court, 1919), physicians could not legally prescribe opium, coca leaves, their salts, derivatives and certain other preparations if the purpose of the prescription was to maintain the comfort of the 'addict.' Following those decisions, this country embarked upon a drug control and drug...prevention and treatment campaign which had a decidedly 'law enforcement' flavor to it. A small branch of the Treasury Department became the powerful Bureau of Narcotics; thousands of physicians, pharmacists and drug-using citizens were fined and imprisoned; teachers and others, assisted by narcotics agents, began to teach about the 'evils' of drugs and 'the living death' which befalls those who become dependent upon drugs; and eventually the Federal penitentiary system had to be modified in order to accommodate the large numbers of 'criminals' whose 'crime' was being a chemically dependent person.

"This punitive approach toward control of drugs and prevention and treatment of drug use problems continued through the 1950's and into the 1960's, though the American Medical Association, the American Bar Association and others clamored for a change in the direction of a more humane approach. Their efforts to produce change seem to have had little impact until a 1962 Supreme Court decision to the effect that 'drug addiction' cannot be declared a crime. Beginning with this decision, and possibly propelled by a 1963 report of the President's Advisory Commission on Narcotics and Drug Abuse, the retirement of long-time Director of the Bureau of Narcotics Henry Anslinger, and the increased use of drugs among white middle-class youths, a more humane approach to the treatment of drug use problems began to emerge. Though strict punitive laws continued to be passed in the hope that their penalties could deter the non-medical use of drugs and that their regulations could limit unauthorized cultivation, manufacture, distribution, and sale, many observers began to look toward other measures to control drugs and to prevent the development of drug use problems. Among these were teachers, public health officials, physicians, pharmacists, and others who were convinced that the legal measures must be supplemented with less punitive approaches if we were to effectively prevent the development of drug use problems."

- (Chemical Dependency Program Division, 1976)

Why Prevention Efforts Were Initiated

Reducing the demand for drugs is a concern of primary prevention, treatment, and rehabilitation programs. To achieve this goal, all three programs attempt to provide support for an individual so that he/she will be able to resist the attractions of drugs. Treatment and rehabilitation programs aid an individual after he/she is exhibiting dysfunctional behavior. On the other hand, primary prevention, using a public health model, intervenes before the onset of dysfunctional behavior, seeking to nuture the individual so that he/she grows healthy and strong and capable of resisting drug use.

"Prevention is necessary to reduce the escalating human material costs associated with drug abuse. It attempts (1) to prevent people from needing treatment, and (2) to help improve or enhance the quality of life of all individuals so that they will not need to use drugs to cope. The assumption here is that drug-taking is a coping strategy employed by individuals in response to such diverse elements as breakdown in family structure, uncertainty about values; boredom with uncreative and irrelevant school curricula and regimented settings, job discrimination, poverty, age segregation, isolation from adult models, and impersonal institutions."

- (The Pyramid Project, 1975)

"For many persons, today's society produces such severe psychosocial development problems that no single helping profession is prepared to deal with it. A multi-disciplinary approach is needed to deal with many different kinds of needs and problems an individual who uses drugs might have.

"Prevention, therefore, is concerned with identifying and promoting those values, attitudes, skills, and involvements that strengthen a person's ability to live successfully in a stressful environment characterized by ready access to drugs."

- (Prevention Branch, 1975a)

Federal Efforts in Drug Abuse Prevention: 1968-74

"The early Federal community-oriented drug abuse prevention effort resulted in a variety of programs supported by the National Institute on Mental Health (NIMH), the U.S. Office of Education (OE), the Bureau of Narcotics and Dangerous Drugs (BNDD)--predecessor to the current Drug Enforcement Administration--and the White House Special Action Office for Drug Abuse Prevention (SAODAP).

"Community organization strategies were developed, especially by the Office of Education, which identified a variety of organizational approaches and mobilized communities.

"The Division on Narcotics and Drug Abuse in the National Institute of Mental Health funded a range of programs resulting in a variety of community models that became basic reference points for subsequent community prevention activities. In addition, the National Institute on Drug Abuse...developed a new generation of resources (training, technical assistance, etc.) to support the community models that were being developed.

"Although there were many indicators of new patterns of drug use, especially among adolescents and young adults, many communities were not aware of such patterns. As public awareness increased, there was an extraordinary demand for information on drug use and conseqences. Between 1968 and 1973, NIMH distributed more than 22 million pieces of information on drug abuse, supplementing this effort with a continuing mass media public service campaign that began in 1968.... There was an assumption that providing information would discourage drug use and promote drug-free behavior. Sometimes it did. Other times it stimulated curiosity, thereby encouraging experimentation and recreational use. When these latter consequences were noted in 1973, the Federal Government ordered a moratorium on the

TIME, MEDIA, AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES

printing and distributing of Federal drug abuse prevention materials and developed a series of new guidelines for subsequent Federal information.

"The Help Communities Help Themselves Training and Technical Assistance Program (HCHT), of the Office of Education, is an example of the success in mobilizing communities through a low cost/high response product. Over 3,000 schools and communities have been involved in the HCHT program and its successor, the School Team Prevention and Early Intervention Program. The more recent Pyramid Project of the National Institute on Drug Abuse, which acts as a technical assistance broker to community prevention programs, has also been very successful at reaching large numbers of people. The Social Seminar (a series of films, role plays, and program learning texts), when used by trained leaders in conjunction with clearly established community goals, proved a successful community organizing tool. The public education and information programs of the Drug Enforcement Administration and the National Institute on Alcohol Abuse and Alcoholism, as well as the prevention activities of the Department of Defense targeted on its specified population, were all reinforcing activities in support of a positive Federal drug abuse prevention effort.

Early Lessons

"One of the early lessons in drug education was that the best factual information, distributed widely and without regard for the level of psychological and social development or the degree of risk to which an individual or group was exposed, often reinforced what was emerging as a major reason for experimenting with drugs--curiosity.

"In response to this finding, the Federal Government in 1973 declared a moratorium on the production of drug information and issued new guidelines for all Federal agencies publishing drug abuse information materials.

"On February 4, 1974, the moratorium was lifted and new guidelines were issued. (These guidelines) emphasized the notion that it is possible to develop discriminating materials that can reinforce or encourage drug-free behavior. Specifically, the guidelines

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	ensure audience identification and pretesting of material, discourage inconsistent or counterproductive themes, and recommend a range of general themes that should be promoted. The guidelines exclude messages in which fear is the main deterrent, that show the proper use of illegal drugs, and that use stereotypes and authority figures to say, 'Don't Use Drugs.' On the positive side, the guidelines call for messages that stress the complexity of the problem, the inconsistency of society regarding use of the range of psychoactive substances (from alcohol and tobacco to cannabis, psychotropic drugs, and opiates), the inter-action of different variables on drug effects, and alternatives and positive role models for young people." - (Subcommittee on Prevention, 1977)
15 MINUTES	6. LECTURE/DISCUSSION • The concept of prevention. Script: The concept of prevention was first developed in the field of public health and epidemiology. "In the classic epidemiologic formulation, the spread of contagious disease among people depends on the interaction of an agent (the disease germ) with a host (the human organism) as mediated through a particular environment (physical and social). Given this formulation, which is greatly overemphasized here, prevention may, according to standard public health categories, occur at three levels. Primary prevention is aimed at keeping the agent from infecting potential hosts by, for example, immunizing the uninfected parts of the population or quarantining those already infected. Secondary prevention, through early case finding and diagnosis, seeks to limit the disease process among infected individuals in whom the process is not far advanced. Tertiary prevention aims at limiting disabilities among, and if possible rehabilitating, persons in whom the disease process has reached an advanced stage. "As employed in the field of drugs, the concept of prevention has usually meant primary prevention and, to some extent, secondary prevention. In

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	other words, the aim of preventive efforts has been to keep nonusers from becoming illicit drug users, and to help experimental or occasional users revert to nonuse, or at least to keep them from progressing to patterns of heavy use." - (Brotman & Suffet, 1975) In its broadest sense, prevention may be said to include all efforts aimed at reducing the supply of drugs and all efforts aimed at reducing the demand for drugs. "In the purest sense, primary prevention activities are most primary when directed toward those who have not experienced a problem with their chemical use. However, because we are a drug-using society, any given group of people for prevention activities may include those who have never experienced a chemical use problem, those who have experienced a chemical use problem maybe once and those who have experienced a problem more than once but have not been singled out as appropriate for the chemical dependency treatment system. Nevertheless, all people in prevention activites are treated as a group with the intention of measurably reducing the likelihood, frequency, seriousness or duration of chemical use problems. Chemical use problems may be defined as consequences in observable life function areas, such as in family, social relationships, education, employment, finances or health." - (Chemical Dependency Program Division, 1976) • Encourage participants to ask questions or make comments concerning the need to have a functional or operational definition for primary prevention as it relates to their programs.
30 MINUTES Prevention Definitions Newsprint	7. EXERCISE: DEFINITIONS OF PREVENTION NOTE: The purpose of this exercise is to make participants aware of NIDA's conceptualization of prevention as well as definitions in use by the various governmental agencies with which they interact, including NIAAA and their SSA and/or SAA.

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- The trainer records on newsprint NIDA's definitions of prevention and other excerpted definitions and asks participants to circulate around the room and examine these definitions, paying attention to similarities and differences.

NOTE: The trainer should prepare these newsprint sheets in advance of the exercise to continue the flow of the training. Definitions appear in the Participant Manual.

- Trainer processes the definitions:
  - Ask participants to relate these definitions to their own philosophies
  - Examine the assumptions under which their own programs operate
  - Discuss the implications of controversy within the prevention field over exactly what prevention is.

NOTE: Emphasize here the common grounds for cooperation; the trainer might choose to generate a group list of "what we all have in common as preventors" to conclude the exercise. Also, consider whether the definitions need to be changed for rural or ethnic programs.

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10 MINUTES

8. REVIEW/PREVIEW

Script:

In discussing individual concepts of prevention and influencing factors, we have begun to look at the environment in which we work, in which individuals use chemicals, and in which we must work to prevent drug abuse. We have also created a foundation upon which specific prevention programs have been developed. What is going on in the field of drug abuse prevention--what strategies are being implemented across the country?

END OF MODULE II

DRUG ABUSE PREVENTION

AN OPERATIONAL DEFINITION OF DRUG ABUSE PREVENTION

The fundamental objective of drug abuse prevention is to assist youth to develop and mature into healthy productive members of our society. Toward that end, prevention involves the process of "enablement," in which prevention professionals, lay-persons, family members and friends who are concerned, help youth create positive attitudes, values, behaviors, skills and lifestyles that will enable them to mature into happy and competent citizens who need not resort to the use of drugs. The desired outcome of prevention programs is the reduction, delay, or prevention of drug use behavior that is not within the parameters of medical therapy and that disrupts the normal developmental life cycle leading to human competency.

Over the last five years, the concept of drug education has expanded beyond programs that provide youths information or advice concerning drugs and their use. The current conceptual framework for drug abuse prevention programming at NIDA that has evolved from the many prevention programs currently operating at the State and the community level. This framework for prevention operationally defines drug abuse prevention along a continuum of health care programs. The four prevention modalities are information, education, alternatives and intervention programs, with each program type best serving youth at different stages of the drug abuse problem. Treatment and rehabilitation programs complete the continuum and focus upon the drug addict and the recovering drug abuser./l/

Prevention Modalities are defined as follows:

> Information Modalities--Approaches that involve the production and/or distribution of accurate and objective information about all types of drugs and the effects of those drugs on the human systems. Examples include drug information seminars, pamphlet development and distribution.
>
> Education Modalities--Approaches that focus on skill building through use of well-defined and structured affective learning processes. Examples of skills that are to be enhanced include values clarification and awareness, problem solving, decisionmaking, coping with stress, and inter-personal communication. The affective learning processes that are used focus on helping people who may be deficient in the above mentioned skills, but may also serve to reinforce already existing skills. Examples include role playing, peer facilitation, and cross-age tutoring.

/l/Bukoski, Dr. William J., "Drug Abuse Prevention: A Meta-evaluation Process," paper presented at the American Public Health Association Conference, November 4-6, 1979.

Alternatives Modalities--Approaches that provide growth-inducing experiences through which individuals develop increased levels of confidence and self-reliance. Enhancement in these areas is provided through social, occupational, esthetic, affective, and cognitive experiences. Alternatives-based activities are designed to provide exposure to a variety of rewarding activities that offer positive alternatives to drug-taking behavior. Examples include human service delivery in the community, restoration, conservation, and preservation of the environment.

Intervention Modalities--Approaches that focus on the reduction, elimination, and/or delay of drug use, drug use-related dysfunctional behavior, and other problem behaviors prior to onset of serious, chronic, debilitative behaviors. These prevention approaches are able to provide assistance and support to people during critical periods in their lives, when person-to-person communication, sharing of experiences, and empathic listening could contribute to a successful adjustment of a personal or family problem. Examples include professional counseling, rap sessions, and peer counseling.

Prevention settings are defined as follows:

School settings are those in which the major percentage of activity takes place within a school system, and where there are direct linkages to, and involvement with, school officials and functions, often during normal school hours.

Occupational settings are those in which the activities take place in an organization that has legal status as a profit or non-profit making corporation, partnership, or other formally-defined income-generating entity.

Family settings are those in which the major focus is on strengthening family relationships. The family is seen as the group through which the desired outcomes should be addressed.

Community settings are those in which the majority of activities are provided under community auspices, and are concerned with activities which impact on both individuals and the community as a whole. /2/

/2/NIDA, Prevention Branch, "State Prevention Coordinator Grant Program Guidelines," May 1980.

DEFINITIONS OF PRIMARY PREVENTION

1. "Primary drug abuse prevention is a constructive process designed to promote personal and social growth of the individual toward full human potential and thereby inhibit or reduce physical, mental, emotional or social impairment which results in or from abuse of chemical substances."

   - the NIDA Drug Abuse Prevention Delphi, 1975.

2. "The purpose of prevention is to increase the likelihood that individuals will develop drinking-related behaviors that are personally and socially constructive. Negatively stated, prevention programs are aimed at reducing the number of persons whose alcohol-related behavior adversely affects the way they carry on the roles and responsibilities of everyday living."

   - from Planning Prevention Programs, National Center for Alcohol Education

3. "Primary prevention of drug abuse is a constructive process designed to promote personal, social, economic and political growth of the individual toward full human potential; and, thereby, inhibit or reduce personal, social, economic or political impairment which results in or from the abuse of chemical substances."

   - the Center for Multicultural Awareness, a project of NIDA's Prevention Branch

4. "Primary prevention encompasses those activities directed at specifically identified vulnerable high-risk groups within the community who have not been labelled as psychiatrically ill and for whom measures can be undertaken to avoid the onset of emotional disturbance and/or to enhance their level of positive mental health. Programs for the promotion of mental health are primarily educational rather than clinical in conception and operation with their ultimate goal being to increase people's capacities for dealing with crises and for taking steps to improve their own lives."

   - Stephen E. Goldston, Ed.D., Coordinator for Primary Prevention Programs, National Institute for Mental Health

5. "The Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) requires the description of two types of behaviors - behavioral antecedents and consequences - which are useful in designing primary prevention activities, particularly with regard to health promotion and disease prevention.

   o Prevention of behavioral antecedents refers to interventions to reduce high risk behaviors such as teenage drinking, smoking and experimental drug use, which increase the probability of developing physical, emotional and behavioral problems.

   o Prevention of behavioral consequences refers to interventions to prevent the deleterious effects (consequences) of high-risk behavior, such as accidents resulting from drinking while driving, or suicides or homicides resulting from emotional disorders, excessive drinking, or substance abuse.

- ADAMHA Prevention Policy Paper, August 17, 1979

6. "An aggregate of community education and social action programs which within an identified length of time and for specified groups of people, are able to measureably reduce the likelihood, frequency, seriousness, or duration of chemical use problems by means other than referral or recourse to the chemical dependency treatment system or correctional services."

   - (The content of this definition was developed by the Michigan Office of Substance Abuse Services prevention staff.)

7. Primary prevention of social and behavioral problems is accomplished through ongoing processes that provide opportunities for individuals, small groups and organizations to increase: 1) knowledge or awareness of personal and collective potentials; 2) skills necessary to attain those potential; and 3) creative use of resources to the end that all people have the ability to effectively cope with typical life problems and recognize, reduce or eliminate unnecessary or debilitating stress in the community without abusing themselves or others and prior to the onset of incapacitating individual, group or organizational problems.

   - (The content of this definition was developed by the Human Services Training Institute, Michael B. Winer, Association Director, Spokane, Washington.)

8. Prevention includes purposeful activities designed to promote personal (emotional, intellectual, physical, spiritual, and social) growth of individuals and strengthen the aspects of the community environment which are supportive to them in order to preclude, forestall, or impede the development of alcohol and other drug abuse problems.

   - Wisconsin State Drug Abuse Plan

9. Another way to break down the concept of health promotion is to consider the community as well as the individual. We are accustomed to think of an individual's health, both in terms of treatment and building resistance, but we can extend this to the community. Often people succumb to ill health in part as a result of forces in the social context. Such could include unemployment, insensitive institutions, including schools, or prevalent attitudes which reinforce unhealthy behaviors. If this is the case, then it makes sense to design programs which deal with these factors.

   - Vermont Alcohol and Drug Abuse Division

10. The National Association of Prevention Professionals' defines prevention as a proactive process utilizing an interdisciplinary approach designed to empower people with the resources to constructively confront stressful life conditions.

MODULE III

MODULE III: CURRENT PREVENTION STRATEGIES **TIME:** 3 HOURS 20 MINUTES

GOALS

- Familiarize participants with existing drug abuse prevention programs and strategies, as categorized by NIDA's prevention continuum
- Acquaint participants with a variety of prevention program choices.

OBJECTIVES

At the end of this module, participants will be able to:

- Identify at least one current prevention strategy for each component of NIDA's prevention continuum
- Identify the major target areas for drug abuse prevention programs
- List at least five existing prevention programs and describe their general approaches
- List at least three prevention approaches that are consistent with their individual prevention philosophy.

MATERIALS

- Newsprint
- Magic Markers
- Pencils
- Diagrams

  - NIDA continuum
  - Prevention programs
  - Correlate research examples
  - CMA model

- Worksheets

  - Matrix

MODULE III OVERVIEW

EXERCISE	TIME	METHODOLOGY
1. PREVENTION MODELS-- IMPLICATIONS FOR PROGRAMMING	45 MINUTES	LECTURE/DISCUSSION
2. TARGET GROUPS	10 MINUTES	LECTURE/DISCUSSION
3. CORRELATES OF DRUG ABUSE	20 MINUTES	LECTURE
4. DEVELOPMENTAL FACTORS	15 MINUTES	LECTURE
5. SUMMARY	5 MINUTES	DISCUSSION
6. THE MULTICULTURAL OR COMMUNITY DEVELOPMENT MODEL	20 MINUTES	LECTURE/DISCUSSION
7. TYING IT ALL TOGETHER	30 MINUTES	SMALL-GROUP EXERCISE
8. SUMMARY	5 MINUTES	DISCUSSION

TIME, MEDIA, AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
45 MINUTES	1. LECTURE/DISCUSSION: PREVENTION MODELS--IMPLICATIONS FOR PROGRAMMING

NOTE: The trainer will introduce this module by referring back to the definitions of prevention discussed during the previous module, drawing attention to the two definitions (the Prevention Delphi definition and the Center for Multicultural Awareness definition) that reflect alternative models for designing drug abuse prevention program.

- The Prevention Delphi Definition--a psychosocial approach to drug abuse prevention.

Script:

"Primary Drug Abuse Prevention is a constructive process designed to promote personal and social growth of the individual toward full human potential and thereby inhibit or reduce the physical, mental, emotional, or social impairment, which results in or from abuse of chemical substances."

The three basic themes that emerged during the Delphi process were:

- Primary prevention must be understood in terms of the development and reinforcement of positive behavior
- Primary prevention programs must be responsive, both in design and operation, to the needs of those they are intended to serve
- Primary prevention programs should, whenever possible, employ collaborative efforts in order to utilize the capacities and resources of existing human service institutions.

Based upon the Delphi definition, NIDA's Prevention Branch has developed and advocated a conceptualization of drug abuse prevention activities that consist of the following continuum.

- Trainer discusses NIDA's continuum and program modalities (Figures III-l and III-2, pp. 69 and 70), using the following definitions.

TIME, MEDIA, AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES

Script:

Four basic models underlie NIDA's drug abuse prevention activities:

Media-Based Information/Education Campaigns.

"Projects designed along the lines of this model involve the dissemination of facts, opinions, and other information about drugs, drug use, and drug abuse through the printed, electronic, and other media. Information is not to be confused with news stories or feature articles about drug use, treatment programs, fund raising, NIDA activities, or the like.

"The purpose of general media campaigns is to reinforce positive behavior and attitudes toward drug use among the general public. Specific media messages are targeted toward specific groups (youth, the elderly, minorities, etc.) to reinforce positive behavior, deter destructive drug-taking caused by ignorance, and/or reduce the level of risk involved in drug-taking behavior among members of the target group."

Education Programs

"These programs include any formal course, curriculum, or training program designed to reinforce positive behavior (i.e., those behaviors that are incompatible with drug abuse or that encourage responsible drug use). Also included are programs designed to change attitudes and/or behaviors that correlate with drug abuse.

"Services provided by these programs include courses in the pharmacology of drugs, parent effectiveness training, decision making, and problem solving. The emphasis is upon formal courses, workshops, and discussion groups. Target groups include non-users of drugs, drug abusers, members of high-risk groups, and the people who most influence such groups."

Alternatives to Drug Use

"This model includes programs designed and/or managed by the target group. Target groups include persons engaged in behaviors that correlate highly

TIME, MEDIA, AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
	with dysfunctional drug use or social/demographic groups in which research has shown drug use to be disproportionately high. Programs of this type are characterized by the development of services as well as their actual provision. Focal activities include service, career, and occupational alternatives, community restorations, self-understanding, relaxation therapy, youth leadership, and skills development. Programs attempt to change attitudes and behaviors from a sense of powerlessness and non-direction to one of self-worth, personal power and self-direction." NOTE: Refer participants to "Alternatives" tables on p. 119 of the Participant Manual. Intervention Programs "These programs are designed for high-risk clients, their families, and service providers. Such programs are characterized by group counseling, individual counseling, and group activities as alternatives to drug use. The focus is upon restructuring the client's environment, social patterns, and self-concept. Clients include persons adjudicated as drug abusers (i.e., marijuana conviction, minor or first offense drug selling, and so forth), and persons not adjudicated but identified by school, parents, or friends as recreational or high-risk drug users. In addition to direct counseling services, a variety of other supportive activities, such as education programs and treatment referral services, are provided." - (Retka, 1977) NOTE: The discussion of "intervention" may raise questions about distinctions between prevention and treatment. Note NIDA's continuum; remind participants that strict definitions of primary prevention may not include intervention activities.
10 MINUTES	2. TARGET GROUPS Introduction: The target groups for prevention may be categorized in at least five ways:

1. Chronological--youth, elementary school, elderly
2. "High risk"--individuals in life crises, "troubled" adolescents
3. Special populations--racial and ethnic minorities, women, and youth
4. Level of focus--individual, family, peer group, larger organizations, and society
5. Patterns of use--as explained below.

Script:

"[The] principal target groups for prevention programs have been defined as non-users, experimenters, and social/recreational users--those who have not yet become habituated to drug use. Understandably, this population group is largely composed of young people, although prevention also embraces the adult scene. A major objective is to interact with youth--the population at greatest risk--and to provide constructive alternatives to drug-taking behavior as a means of coping with life's problems."
- (Jackson, 1976)

The target population can be illustrated by the "Target Populations for Primary Prevention and Treatment" diagram (Figure III-3, on p. 69 in the Participant Manual).

- Explain each category.

Script:

1. Nonusers: Self-explanatory; persons who have never tried an illicit drug.
2. Experimenters: Drugs do not play a regular role in their life. Use is episodic and reflects a desire to see what the drug is like or to test its effect on activities that are ordinarily experienced drug free. The drug usually is tried once or twice but, for various reasons, use is discontinued.
3. Socio-Recreational: This behavior occurs in social settings among friends or acquaintances.

It reflects a desire to share an experience that is defined as both acceptable and pleasurable. The pattern of drug use is occasional and situationally controlled. The drugs are associated with activities in which this type of user would take part, whether or not drugs were present.

4. Circumstantial: This behavior is generally motivated by the user's perceived need or desire to achieve a new and anticipated effect in order to cope with a specific problem situation or a vocational condition (e.g., a long-distance truck driver).

5. Chronic or Intensified: These subgroups are self-medicators. Both groups often use drugs as a type of self-therapy, among other reasons. Time is dedicated to seeking out drugs or making connections to obtain them. The user cannot enjoy or cope with situations without drugs. The self-medicator typically uses tranquilizers or stimulants that are distributed legally. This type of use may become a habitual way of responding to boredom, loneliness, frustration, or stress.

   (A salient feature of these four user categories is that the individual still remains integrated within a larger social and economic structure. Drug use takes place in both social and nonsocial settings.)

6. Addicted or Compulsive: This category is characterized by a high degree of psychological dependence and perhaps physical dependence. Drugs dominate the individual's existence; this preoccupation with drug taking precludes most kinds of social functioning. The process of securing and using drugs interferes with essential activities.

- Two useful frameworks for examining possible prevention activities aimed at these target populations are:

  1. Research findings of the correlates to drug abuse

2. Developmental factors of "at risk" populations.

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20 MINUTES

3. CORRELATES OF DRUG ABUSE

- Trainer should use the correlate review handout (Reference Sheet III-1, p. 74) to discuss related behavioral problems around which drug abuse prevention strategies may be developed.
- Encourage participants to ask questions or make comments throughout the lecture/discussion.

NOTE: Select examples from the quotes listed below.

Script:

Since 1966, research has shown that the causes for and problems of chemical use are related to the lack of development of techniques for healthy functioning of an individual. Supporting evidence can be found in the following research:

"As an antecedent to drug abuse, low self-esteem may cause the individual to be vulnerable to other pressures and stresses in life that influence him toward drug abuse. As a consequence of drug abuse, on the other hand, low self-esteem may result from the individual's attribution of his or her present crisis to his or her own ineptitude or lack of worthiness.... A more likely hypothesis is that low self-esteem has led to or had been associated with the beginning of drug abuse."

- (Norem-Hebeisen & Ahlgren, 1976)

In several research articles, drug abusers were considered as showing evidence of long-term identity problems and failing to assimilate a maternal image. Both parents were viewed as self-reliant, in pursuit of socially approved goals, and exhibiting little interdependency. Beneath this external pattern, however, one often finds a family characterized by emotional and environmental deprivation and communication deficiencies.

"For a child growing up in this family system, the child may emulate the parental model of social responsibility and strive toward socially approved goals. If, however, the child cannot formulate meaningful goals, lacks confidence in his ability to compete successfully, or questions that closeness in his or her family is even attainable, he or she may renounce the former and seek the latter elsewhere. The anxiety provoked by this situation must then be circumvented since the child has neither experienced intimacy in earlier development, nor learned to exhibit fear or acknowledge weakness. Thus, use or abuse of illicit drugs can become one route for appearing strong and self-assured while feeling a pseudointimacy with others engaging in the same behavior."

- (Cohen, White, Schooler, & Houston, 1971)

"Adolescents with no drug problems perceive themselves, are perceived by family members to receive, and are observed to receive significantly more emotional support than did drug-abusing adolescents; pre-adolescents in drug free families also obtained more perceived and observed support than did the pre-adolescent with a drug using adolescent brother."

- (O'Dowd, 1973)

"Problem drinking is positively related to anxiety, depression and a higher level of alcohol consumption."

- (Williams, 1966)

"A relationship exists between frustration, dissatisfaction, powerlessness, and alcohol intake and frequency of intoxication."

- (Jessor, Young, Young, and Tesi, 1970)

"Adolescent chemical users are more subject to deficient parental models."

- (Rosenberg, 1969)

"Marijuana users value achievement less, independence more, tend toward greater alienation and social criticism, are more tolerant of deviance, less religious, less compatible between peers and parents, more subject to pressures from peers, indulge less frequently in conventional activities (church, clubs, etc.), and more frequently in deviant behavior attributes: lower value on achievement and greater value on independence; greater social criticism, less

religious, more tolerant of deviances; less parental control, heavy peer pressure influence; lower school achievement than non-users."
- (Jessor, 1975)

"Adolescents who manifest low expectations for achieving valued goals would be more likely to report greater social complication from drug use."
- (Carman, 1974)

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15 MINUTES

4. DEVELOPMENTAL FACTORS

- Dr. Stephen Glenn has utilized the literature on adolescent development to identify some of the common behavioral and developmental issues that may either foster or inhibit the destructive use of chemicals.

Script:

While explanations of the causes of drug-dependent behavior vary considerably across disciplines (i.e., medical, psychological, sociological, cultural, economic, legal, etc.), the resultant outcome in terms of an individual's learning or developmental profile appears to be consistent.

Developmental Characteristics

In general, the "high-risk" individual shows significant inadequacies in one, several, or all of the following areas:

1. Identification with viable role models: This refers to a person's reference group and self-concept. The vulnerable person does not see himself of herself as like (or the same as) people whose attitudes, values, and behaviors allow them to "survive" in their total environment.

2. Identification with and responsibility for "family" processes: When poorly developed, a person does not identify strongly with things greater than himself or herself (e.g., relationships with another person, in groups, mankind, God, etc.). He or she does not see that what he or she does affects others. This refers to

shared investment in outcomes, shared responsibility for achieving outcomes, and accountability to others for behavior.

3. Faith in "miracle" solutions to problems: This refers to the skills and attitudes necessary to work through problems and the belief that they can be solved through application of personal resources. When poorly developed, a person believes that problems have been escaped when he or she can't feel them (through use of drugs, alcohol, etc.) anymore. He or she does not believe that there is anything he or she can do about the present or future; things just happen to him or her.

4. Intra-personal skills: This refers to the skills of self-discipline, self-control, self-assessment, etc. Weaknesses in these areas express themselves as: inability to cope with personal stresses and tensions; dishonesty with self; denial of self; inability to defer gratification; etc.

5. Inter-personal skills: This refers to the ability to communicate, cooperate, negotiate, empathize, listen, share, etc. Weaknesses in these areas express themselves as dishonesty with others, lack of empathic awareness, resistance to feedback, inability to share feelings, give or receive love or help, etc.

6. Systemic skills: This refers to the ability to respond to the limits inherent in a situation (responsibility); the ability to adapt behavior to a situation in order to get one's needs met (adaptability) constructively; etc. Weaknesses in these areas express themselves as irresponsibility, refusal to accept consequences of behavior, scapegoating, etc.

7. Judgmental skills: Refers to the ability to recognize, understand, and apply relationships. Weaknesses in this area express themselves as crises in sexual, natural consumer and drug environments, repetitious self-destructive behaviors, etc.

Most human behavior is a composite of the seven areas described above. Social norms define acceptable forms of behavior, and require certain levels of functioning in each of these areas. By assessing levels of functioning or development against norms, as socially and environmentally defined, these developmental characteristics are used as diagnostic indicators of "high-risk" and "low-risk" populations for purposes of both prevention and treatment. At present, treatment and prevention programs have both explicit (expressed) and implicit (implied) goals, which reflect the above characteristics. An analysis of these goals suggests that, in virtually all current approaches to prevention, rehabilitation, and therapy, workers are attempting to establish or maintain situations in which their clients, through practice and experience, can:

- Strengthen or develop intra-personal skills (get self together) and/or
- Strengthen or develop inter-personal skills (learn to deal effectively with others) and/or
- Strengthen or develop systems skills (learn to handle situations) and/or
- Develop problem solving abilities and/or
- Strengthen identification with and responsibility for "family" processes (become part of something greater than self and learn to carry his/her own weight) and/or
- Strengthen identification with viable role models (learn to see self as the kind of person who is making it).

- (Adapted from Glenn, 1977)

5 MINUTES

5. SUMMARY

- Trainer summarizes the major components of the psychosocial model of drug abuse prevention, which focuses on increasing the individual's ability to cope with his/her environment.

TIME, MEDIA, AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
20 MINUTES	6. LECTURE/DISCUSSION: THE MULTICULTURAL OR COMMUNITY DEVELOPMENT MODEL

NOTE: The following material is quoted from an unpublished paper by Byron Kunisawa, consultant to the Center For Multi-Cultural Awareness. Be certain to adapt the material to your own language and style.

Script:

"The findings of the NIDA Delphi process did much to focus government efforts on primary prevention. However, the Delphi process, by definition, reflects group consensus, the majority, or the norm. Consequently, the special needs and considerations of minorities had a tendency to be 'washed out' in the process: Their needs simply were not part of the prevention mix. The emphasis on social competency skills (alternative and educational approaches) encouraged minority individuals to assimilate middle-class values and to adjust to the hopelessly oppressive social conditions on reservations, in ghettos, and in barrios. It was like serving a pie with a large piece missing and all the while knowing there won't be enough to go around...Guess who don't get no pie?"

Minority Drug Abuse Prevention

"Awareness of the problem led to the formation of professional activist groups of minority drug abuse workers, such as the National Indian Board on Alcohol and Drug Abuse, the Black Substance Abuse Task Force, the Chicano Alliance of Drug Abuse Programs, the National Association of Puerto Rican Drug Abuse Workers, and others. For minorities to survive without giving in to total assimilation, without disappearing, they would have to change a system that had never accepted the cultural differences that make them separate or unique. In order to bring about these changes, minorities must have the political and economic power essential to institute change.

"By organizing and forming coalitions to petition both the public and government agencies, minorities began to make themselves heard and began to obtain

TIME, MEDIA, AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES

the types of services needed to combat drug abuse in our communities.

"The National Institute on Drug Abuse realized that minority communities were not being reached by NIDA's prevention efforts and created a focal point for the advocacy of minority drug abuse prevention, to coordinate, develop, and disseminate prevention resources and strategies for minorities (information, publications, training, and technical assistance). These resources and materials were to address each of the five major minority groups (Asian/Pacific Islanders, Blacks, Mexican Americans, Native Americans, and Puerto Ricans). A key to the success of this delivery system was the involvement of members of the five minority groups in planning, developing, field testing, and delivering the resources to minority populations.

"In May 1977, the annual National Drug Abuse Conference was the first opportunity for minorities to participate in the planning of a national forum where people of many ethnic groups, life-styles, backgrounds, disciplines, and ages could come together to develop the kind of knowledge and sensitivity that would enhance the development of policies and programs.

"At that gathering, minority leaders presented evidence that racial discrimination, lack of equal opportunity, and exclusion of minorities from the mainstream of our society can be linked directly to the causes of drug abuse in minority communities.

"The minority group leaders also informed NIDA that the resources available to combat drug abuse were seldom relevant to minorities because they had been developed by members of the majority who directed their efforts towards others like themselves. In the field of prevention, minority issues had been neglected and this neglect needed to be redressed in order to strengthen the self-concepts and the life survival skills of minority group members.

A New Definition of Prevention

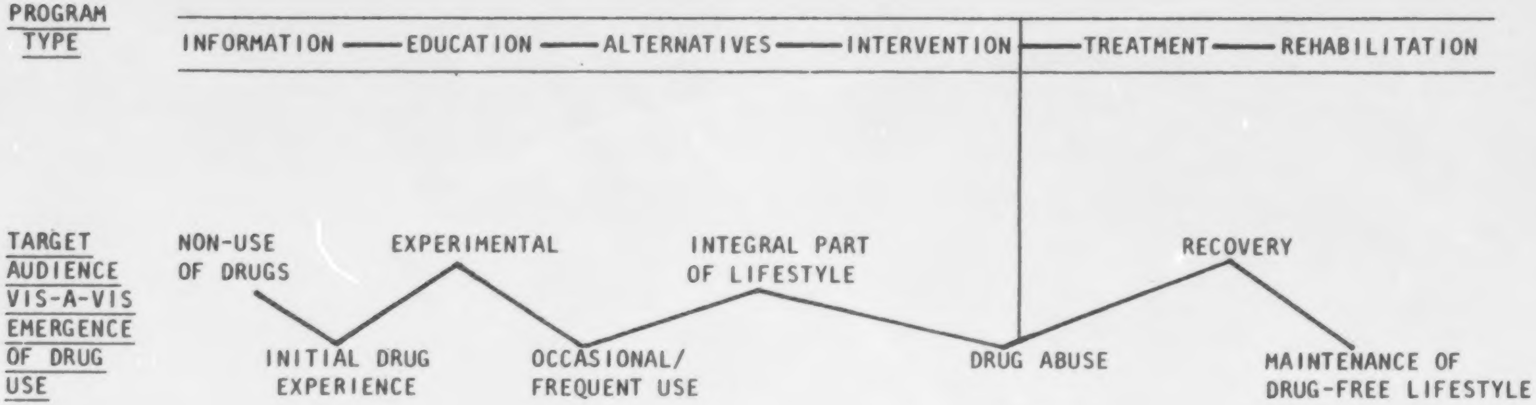
"In this context, the definition of primary prevention should be:

MODULE III: CURRENT PREVENTION STRATEGIES

TIME, MEDIA, AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
	Primary prevention of drug abuse is a constructive process designed to promote personal, social, economic, and political growth of the individual toward full human potential; and, thereby, inhibit or reduce personal, social, economic, or political impairment which results in or from the abuse of chemical substances. "However, if this definition is for minorities only, we will still have a 'rider' program. For prevention to be a reality for any one group or individual, all programs must enhance personal, social, economic, and political growth." - (Center for Multicultural Awareness)
10 MINUTES	● Trainer uses Center for Multicultural Awareness Model diagram (Figure III-4, p. 72) to discuss the "individual empowerment and systemic change" emphasis of the multicultural model of drug abuse prevention. NOTE: At this point, if appropriate to your training audience, you may want to continue the scenario of the evolution of prevention to address widening target populations by noting the growing attention to the needs of rural populations.
30 MINUTES "Drug Abuse Prevention Matrix" Worksheet	7. EXERCISE: TYING IT ALL TOGETHER ● Ask individuals to use the NIDA Prevention Matrix worksheet (Worksheet III-1, p. 73) and fill in as many of the boxes as possible with the names and/or brief descriptions of programs with which they are personally familiar. NOTE: You might choose to use the worksheet as a Tic-Tac-Toe game and award prizes for completion of either a row or the entire worksheet.
Newsprint	● Individuals then self-select into small groups. Each small group should select one level of intervention, i.e., individual, family, peer, etc., and brainstorm on a sheet of newsprint as many program strategies as possible to address that particular level of intervention.

TIME, MEDIA, AND MATERIALS	*OUTLINE OF TRAINING ACTIVITIES*
	● Report out: The trainer processes the responses, to include consideration of - What levels were chosen and why? - What range of programs was suggested? - What prevention models did these choices represent? NOTE: The trainer should make note of any rural or ethnic differences that emerge from this exercise.
15 MINUTES	● " What fits for me?" Trainer asks individuals to reflect on their own concepts of drug abuse prevention. Individuals should then circle five of the strategies on their matrix worksheets that are consistent with their personal philosophies.
	8. SUMMARY ● Trainer introduces the next module on community needs assessment by emphasizing that, regardless of program emphasis--individual change or community development--every prevention program must be developed within and supported by its own community. Knowing your community is the cornerstone of every effective drug abuse prevention program.
	END OF MODULE III

DRUG ABUSE PROGRAM CONTINUUM


PROGRAM TYPE
INFORMATION —— EDUCATION —— ALTERNATIVES —— INTERVENTION —— TREATMENT —— REHABILITATION
TARGET AUDIENCE VIS-A-VIS EMERGENCE OF DRUG USE
NON-USE OF DRUGS
INITIAL DRUG EXPERIENCE
EXPERIMENTAL
OCCASIONAL/ FREQUENT USE
INTEGRAL PART OF LIFESTYLE
DRUG ABUSE
RECOVERY
MAINTENANCE OF DRUG-FREE LIFESTYLE

MODULE III: CURRENT PREVENTION STRATEGIES--2 **FIGURE**

PREVENTION PROGRAMS

INFORMATION

- Accurate information
    - -Legal and illegal drugs and their effects
- Target specific for maximum results

ALTERNATIVES

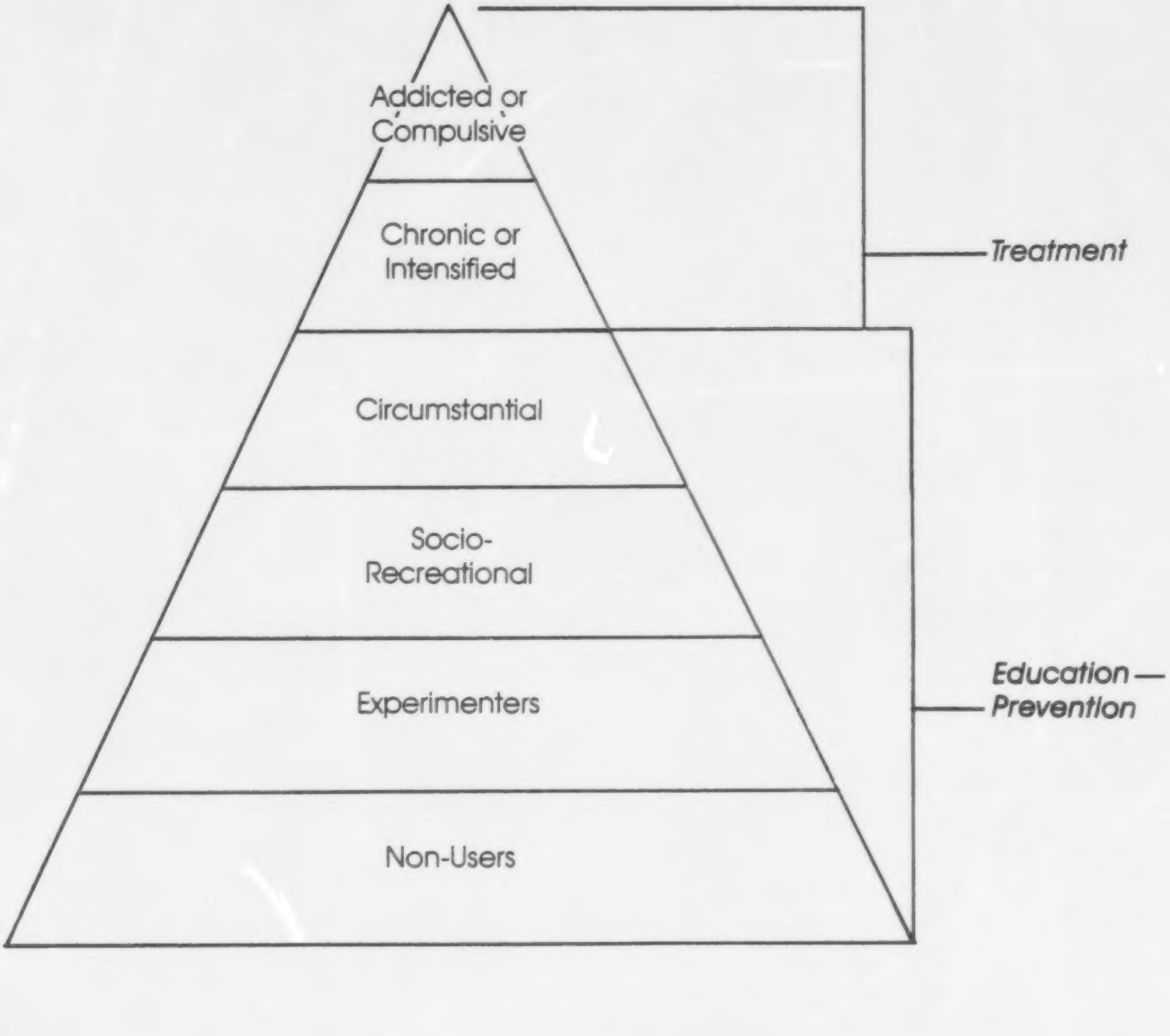
- Constructive activities that meet developmental needs of youth
- Ownership and self-investment
- Constructive peer pressure

EDUCATION

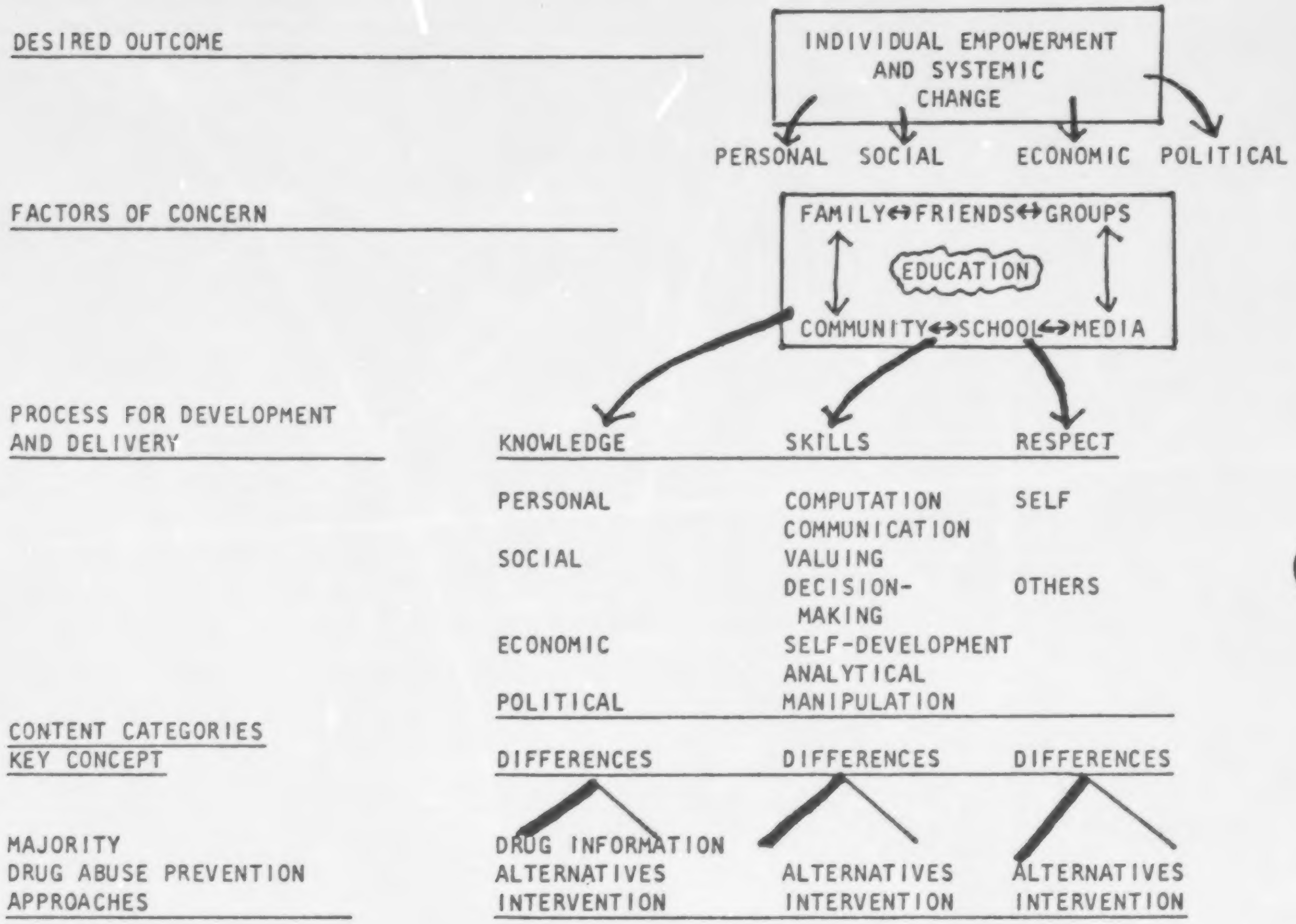
- Process to help individuals develop skills to help themselves
    - -Decisionmaking skills
    - -Values awareness
    - -Communications
    - -Self-understanding
    - -Parent-family involvement
    - -Curricula
    - -Counseling

INTERVENTION

- Specific assistance and support for youth usually at high risk
    - -Counseling
    - -Hot lines
    - -Cross-age tutoring
    - -New peer group creation


Addicted or Compulsive
Chronic or Intensified
Circumstantial
Socio-Recreational
Experimenters
Non-Users
Treatment
Education — Prevention

MULTICULTRUAL DRUG ABUSE PREVENTION--AN IMPLEMENTATION DESIGN


DESIRED OUTCOME
INDIVIDUAL EMPOWERMENT AND SYSTEMIC CHANGE
PERSONAL
SOCIAL
ECONOMIC
POLITICAL
FACTORS OF CONCERN
FAMILY↔FRIENDS↔GROUPS
EDUCATION
COMMUNITY↔SCHOOL↔MEDIA
PROCESS FOR DEVELOPMENT AND DELIVERY
KNOWLEDGE
SKILLS
RESPECT
PERSONAL
SOCIAL
ECONOMIC
POLITICAL
COMPUTATION
COMMUNICATION
VALUING
DECISION-MAKING
SELF-DEVELOPMENT
ANALYTICAL
MANIPULATION
SELF
OTHERS
CONTENT CATEGORIES
KEY CONCEPT
DIFFERENCES
DIFFERENCES
DIFFERENCES
MAJORITY DRUG ABUSE PREVENTION APPROACHES
DRUG INFORMATION
ALTERNATIVES
INTERVENTION
ALTERNATIVES
INTERVENTION
ALTERNATIVES
INTERVENTION

DRUG ABUSE PREVENTION MATRIX

MODALITY

FOCUS	INFORMATION	EDUCATION	ALTERNATIVES	INTERVENTION
INDIVIDUAL				
FAMILY				
PEERS				
SCHOOLS				
OTHER SOCIAL INSTITUTIONS				

DRUG ABUSE CORRELATES - Selected Examples

Research has investigated the relationship of drug abuse to other adolescent behaviors, attitudes, characteristics, and environments. It is important to remember that these relationships are correlative (i.e. so related that each implies or complements the other) rather than causal. To reiterate, no empirical research exists which definitely establishes the causes of drug abuse; much information has been gathered around the attitudes and behaviors which are associated with the destructive use of drugs, as well as other self-destructive use of drugs, as well as other self-destructive and anti-social behaviors.

In an early (October, 1976) reveiw of correlate research, NIDA's Prevention Branch outlined six categories of correlate research:

1. Individual correlates
   a. Personality (e.g., attitudes towards self, values, social, and political attitudes, locus of control, achievement orientation, peer or adult orientation)
   b. Behavioral (e.g., school or vocational performance, interpersonal or group involvement, recreational, and avocational activities)
   c. Demographic (e.g., age, religion, ethnicity, geography, and socio-economic status)
2. Family correlates
   a. Intra-family interactions (e.g., child raising practices, rituals and habits, power and status dynamics)
   b. Family structure/status (e.g., size, birth order, and socio-economic status)
   c. Characteristics of the family group members (e.g., parent and sibling use patterns)
3. Peer group correlates
   a. Peer group norms/interest (e.g., drug use patterns, values, participation in organized activities)
   b. Peer group structure/status (e.g., group size, stability of the group, and intra-group dynamics)
4. School-related correlates
   a. School structure/policy (e.g., policy-making procedures, punishment and grading practices, and general orientation towards education)
   b. Classroom climate (e.g., content of curriculum and characteristics of teacher)

   c. Drug-specific policies procedures (e.g., drug education programs, rules, and penalties regarding drug use)

5. Community correlates

   a. Community demographics (e.g., ethnicity, urban/suburban/rural, socio-economic status, and stability)

   b. Community service policies (e.g., recreational, cultural, human services, and law enforcement)

6. Societal correlates

   a. Societal structure/policy (e.g., economics, legislative and enforcement policies, and mass media influences)

   b. Cultural norms, values, myths.[1]

Research has established both positive and negative correlations of drug abuse and attitudes and behaviors. Some examples are:

1. Drug abuse has been positively correlated with:

   a. Knowledge of drugs (Fejer, D. & Smart, 1973)

   b. Attitudes towards use (Fejer, D. & Smart, 1973)

   c. Iintentions to use (Tzeng and Skafidas, 1975)

   d. Use of other drugs (Annis, H.M., 1971)

   e. Impulsivity (Cisin, I. & Cahalan, 1978)

   f. Alienation (Block, J.R., 1975)

   g. Excessive personal stress (Duncan, 1977)

   h. Sensation seeking (Segal, B., 1975)

   i. Boredom (McLeod & Grizzle, 1972)

   j. Assertiveness (Horan, J., D'Amico & Williams, J., 1975)

   k. Anti-social tendencies (Galli, N. & Stone, 1975)

   l. Rejection (Braucht et al., 1973)

   m. Reliance on peer group for drug information (Guinn, K., 1975)

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[1] NIDA Prevention Branch, "Correlate Research Review, "Division of Resource Development, National Institute on Drug Abuse, Rockville, Md. 20857, October 1976.

Reference Sheet III-1 Continued

n. Skepticism about school drug education programs (Fejer and Smart, 1973)

o. Septicism about media prevention efforts (Hughes, Sanders, & Schaps, 1977)

p. Peer approval of deviant behavior (Jessor, R., 1971)

q. Peer pro-drug attitudes and behaviors (Bowker, L.H., 1974)

r. Parental use of drugs or alcohol (Annis, H., 1971)

s. Parental medication use (Blum, R.H., 1972)

t. Lack of parental concern (Baer & Corrado, 1974)

u. Parental permissiveness (Baer & Corrado, 1974)

v. Childhood stress and trauma (Pittel, S. et al., 1971)

w. Absence of a parent (Carney, Timmes, & Stevenson, 1972)

x. Family instability & disorganization (Braucht et al., 1973)

y. Quality of the relationship in the family (Bracht et al., 1973)

z. Over- and under-dominated by parents (Bracht et al., 1973)

aa. Harsh physical punishment (Baer & Corrado, 1974)

bb. Rejection by parents (Braucht et al., 1973)

2. Drug abuse has negatively correlated with:

    a. Self-esteem (Smith and Fogg, 1975)

    b. Liking of school (McLeod & Grizzle, 1972)

    c. Grades and achievement (Guinn, 1975 and Carnat, 1972)

    d. Decision making (Segal, 1975)

    e. Self-reliance (Segal, 1975)

    f. Feelings of belonging (Galli & Stone, 1975)

    g. Religious beliefs (Smith & Fogg, 1975)

    h. Optimism about the future (Mellinger, Sommers, & Mannheim, 1975)

    i. Humanistic environment in the school (McLeod & Grizzle, 1972)

    j. Alternate education programs for drop-outs and underachievers (Korotkin, 1975)

Reference Sheet III-1 Continued

k. Involvement of community institutions in youth problems and programs (Channel 1, Exodus)

l. Clear, consistent child rearing practices (Jessor and Jessor, 1972)

m. Parent religiosity (Jessor & Jessor, 1972)

n. Parental intolerance of deviance (Prendergast, 1974)

o. Presence of controls and regulations in home (Hunt, 1975)

p. Extended family (Blum, R.H., 1972)[2]

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[2] From the NIDA Prevention Briefing Book, Prevention Branch, Division of Resource Development, National Institute on Drug Abuse, Rockville, Md. 20857, 1979.

MODULE IV

MODULE IV: KNOWING YOUR COMMUNITY **TIME:** 3 HOURS

GOALS

- Examine important factors in selecting prevention strategies
- Provide trainees with direction in identifying needs and resources within their own communities.

OBJECTIVES

At the end of this module, participants will be able to:

- List at least five critical factors participants will consider in developing a drug abuse prevention program for their community
- List 4 major interest groups in their community
- Develop a profile of their community strengths, resources, and values.

MATERIALS

- Newsprint
- Pencils
- Magic Markers
- Worksheets

    - Social Compass
    - Community Functions

MODULE IV — OVERVIEW

EXERCISE	TIME	METHODOLOGY
1. INTRODUCTION	5 MINUTES	LECTURE
2. ELEMENTS OF A COMMUNITY	1 HOUR, 5 MINUTES	LECTURE/DISCUSSION
3. WHAT GOES ON IN A COMMUNITY?	30 MINUTES	LECTURE/DISCUSSION
4. DEVELOPING A COMMUNITY PROFILE	45 MINUTES	INDIVIDUAL EXERCISE
5. REVIEW/PREVIEW	5 MINUTES	LECTURE

5 MINUTES

1. INTRODUCTION

- Trainer tells the following story.

Script:

"Once upon a time, there was a man who strayed from his own country into the world known as the Land of Fools. He soon saw a number of people flying in terror from a field where they had been trying to reap wheat.

"'There is a monster in that field,' they told him. He looked, and saw that it was a watermelon. He offered to kill the 'monster' for them. When he had cut the melon from its stalk, he took a slice and began to eat it. The people became even more terrified of him than they had been of the melon. They drove him away with pitchforks, crying, 'He will kill us next, unless we get rid of him.'

"It so happened that at another time another man also strayed into the Land of Fools, and the same thing started to happen to him. But, instead of offering to help them with the 'monster,' he agreed with them that it must be dangerous, and by tiptoeing away from it with them he gained their confidence. He spent a long time with them in their houses until he could teach them, little by little, the basic facts which would enable them not only to lose their fear of melons, but even to cultivate them themselves."

- (The Sufi Teaching-Tale of the WaterMelon Hunter)

20 MINUTES

2. LECTURE/DISCUSSION

NOTE: Knowing your community is the key to developing and maintaining effective drug abuse prevention programs.

- Trainer introduces the Center for Multicultural Awareness Social Compass (Figure IV-1, p. 92) and explains the various components of the compass (Legend).

NOTE: While developed for ethnic minorities, explain that every community has the same

TIME, MEDIA, AND MATERIALS

OUTLINE OF TRAINING ACTIVITIES

constituent elements. Also, emphasize that the purpose of this attempt to describe the community is not an effort to standarize norms and values, but rather, to recognize and utilize existing community characteristics to develop prevention programs.

45 MINUTES

"CMA Social Compass" Worksheet

- Individual worksheets: Individuals fill in as many as possible of the blanks on the social compass for their own community (Worksheet IV-1, p. 96).
- Triads: Individuals share their social compasses.

NOTE: Encourage individuals from the same program or community to work together.

NOTE: Encourage trainees to assist each other in adding more information or asking open-ended questions about the important characteristics of each other's communities.

- In the large group, the trainer processes responses to the exercise, provoking discussion of similarities and differences among communities.

NOTE: Relate back to ethnic and/or rural issues raised in Module III. The trainer might, for example, select one category and ask every trainee to share his/her description of that category for his/her own community, recording that information on newsprint.

- Gaps in participant knowledge of their own communities
- Any particular insights which trainees gained during the exercise
- What parts were most difficult?
- Were the suggestions of other trainees helpful in completing your compass?

NOTE: Just as we began in Module I by asking you to look at each participant's strengths,

TIME, MEDIA, AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
	so it is also important to look at the strengths of his/her community. This process relates to the analogy of looking at the glass of water as half full or half empty.
30 MINUTES	3. LECTURE/DISCUSSION: WHAT GOES ON IN A COMMUNITY?

Script:

Although there are a number of ways of describing a community and all of its aspects, our focus will be on the functioning of the community. Klein (1970) has described community functions as follows:

1. "Providing and distributing living space and shelter and determining use of space for other purposes.
2. Making available the means for distribution of necessary goods and services.
3. Maintaining safety and order and facilitating the resolution of conflicts.
4. Educating and acculturating newcomers (e.g., children and immigrants).
5. Transmitting information, ideas, and beliefs.
6. Creating and enforcing rules and standards of belief and behavior.
7. Providing opportunities for interaction between individuals and groups."

The maintenance of these functions, which are necessary for the survival of the community, is accomplished through the interaction of individuals, groups, and organizations. It should be noted that there is another important element involved in maintaining the community. That element is the natural or physical environment, which includes such characteristics as natural resources, trade and travel routes, distance to other communities, physical size, population density, topography, etc.....If one looks at the history of the community, one would discover

TIME, MEDIA, AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES

that few communities, if any, plan at the outset for the variety of social and health services programs that are eventually needed. Rather, such programs come into being as social and health problems become identified.

Why does the community develop behavioral and social problems? One explanation for the rise in imbalances has primarily to do with change. In understanding the effect of change, it is necessary to look at change not only at the community level (functional change), and at the organizational or small group level (change in personnel and goals), but also at change in the life cycle of the individual. As Klein (1970) has noted:

> The community is the setting for a variety of emotional hazards to which all persons are exposed during their lifetime. Unexpected disruptions, such as those occasioned by accident and illness, loss of loved ones, changes in social role and status, and shifts in relationships occasioned by such events as marriage, change in residence, and the birth of a baby, are all times when individuals experience heightened tension, feelings of malaise and uncertainty, resulting from disruption of familiar patterns and the inadequacy of usual means of coping. Certain hazards, such as the impact on families of birth, bereavement, and marriage, are familiar and repetitive from generation to generation. Because they affect everyone, they have become ritualized within the community through special rites and sacraments....Whether or not rituals are available, the individual facing any hazard is dependent on the resources that a particular community has to offer and is affected by the means of coping that the community either makes available to him/her or denies to him/her.

We find existing in all communities, then, a variety of roles, agencies, and programs to deal with stress and/or problems that arise for each of the subsystems of the community. A majority of the processes that are designed to deal with stress and resultant problems in the community deal with it from a restorative standpoint. That is, they deal with the aftereffects or the casualties of some stress or problem in the community. Because so few community processes are currently designed to deal with problems before they arise, the nature and number of problems reach crisis proportions before being dealt with.

Taking a historical look, we discover that the crisis orientation has evolved from what at one time could have been identified as a laissez faire stance. That is to say that the community, individuals, groups, etc., had an attitude of allowing things to take care of themselves in their own way, and that included doing nothing at all in many cases. Another way of describing the dilemma is to see ourselves as not dealing with change or anticipating change in an effective manner.

Why aren't we dealing with change in a planned or preventative sense? Klein (1970) outlines the following reasons for resistance to change:

1. There is an almost universal tendency to seek to maintain the status quo on the part of those whose needs are being met by it.
2. Resistance to change increases in proportion to the degree to which it is perceived as a threat.
3. Resistance to change increases in response to direct pressure for change.
4. Resistance to change decreases when it is perceived as being favored by trusted others, such as high-prestige figures, those whose judgment is respected, and people of like mind.
5. Resistance to change decreases when those involved are able to foresee how they may establish a new equilibrium as good as, or better than, the old.
6. Commitment to change increases when those involved have the opportunity to participate in the decision to make the change and its implementation.
7. Resistance to change based on fear of the new circumstances is decreased when those involved

have the opportunity to experience the new circumstances under conditions of minimal threat.

8. Temporary alterations in most situations can be brought about by the use of direct pressures, but these changes are accompanied by a heightened tension in the total situation, and therefore yield a highly unstable situation in which major changes may occur suddenly and often unpredictably.

"It should be clear that change is normal. In resisting change, individuals, groups, and organizations are deliberately, but likely unwittingly, forcing a breakdown in the community. The challenge to prevention specialists concerned and dedicated to the need for a preventative approach to solving problems begins with education and attitude change of those institutions which influence policy making, priorities, and distribution of resources."

- (Ingraham, 1972)

The community can be viewed as being composed of twelve functional areas, i.e., existing institutions and activities that create and experience stress. Prevention specialists should recognize that any one or all of these areas can be intimidated by change. These functional areas can be broken down into:

1. Home
2. School
3. Church
4. Neighborhood
5. Health services
6. Social services
7. Recreation and leisure
8. Business and industry
9. Justice and safety
10. Legislature
11. Local government
12. Media.

To introduce primary prevention programs to the community in an optimal fashion could mean introducing change in the community at a variety of levels. Because change is resisted for a number of reasons, as mentioned earlier, potential resistance to the introduction of primary prevention programs must be examined.

Lay as well as professional people seem overwhelmed by the magnitude and complexities of the problems involved. Out of frustration, they tend, on a collective level, to excuse themselves from any responsiblity for ongoing community problems. It becomes too easy to rationalize that "society" is indifferent and that individual problems are great enough without trying to tackle problems at the total community level. Prevention specialists should remind themselves that there is no problem in the community that could not be addressed and changed if a significant number of people in the community decided they would no longer tolerate existing conditions.

Another potential deterrant to primary prevention programs is the high, often impregnable, fortress of personal privacy--the right and privilege of each person (and family) in a free society to choose to live as he/she wishes within agreed-upon limitations.

"Historically, however, it can be demonsrated that when the population at large, or the 'experts' that help to guide the population, deem it necessary or mandatory for the common good, interventions can be and are made on personal behavior. For example, automobile use, school attendance, physical hygiene, sanitation, etc., represent humanistic incursions into the personal domain."
- (Ingraham, 1972)

Viewing primary prevention programs as community-focused change can be understood more clearly by examining how communities typically view prevention and deal with problems. The community's primary mode of dealing with contemporary problems--whether at the individual, group, organization, or community level--is to provide treatment or rehabilitation in its most broad definition--if, and only if, the problem becomes severe enough to demand attention. Almost all funding of community mental health programs supports or directly results in individual and small-group treatment programs on a tertiary prevention (treatment) basis. Consequently, the community mental health movement continues to focus its entire energy on the causalities of community processes rather than dealing with the problems of community that are perceived before any casualties result.

Primary prevention programs are not intended to pose a threat to any existing alternative or belief. On the contrary, the constant interaction between treatment and primary prevention, for example, inevitably can strengthen treatment approaches in many ways, including the following:

1. Primary prevention can increase the probability of early identification of various problems.
2. By reducing or removing some factors contributing to drug abuse, primary prevention can enable prevention and treatment programs to develop complementary approaches.
3. Primary prevention alternatives can increase the probability of returning the treated individual to a manageable environment.

In conclusion, by addressing specific community functional areas, such as the twelve mentioned earlier, broad and unmanageable problems (such as crime, old age, juvenile delinquency, drugs, etc.) can be understood and methods can be developed for dealing with these issues. The prevention specialist's task is to recognize that each of the twelve functional areas has the ability to expand awareness, develop skills, and create a supportive environment.

- Ask for any final questions and comments.

45 MINUTES

"Community Functional Areas" Worksheet

4. EXERCISE: DEVELOPING A COMMUNITY PROFILE

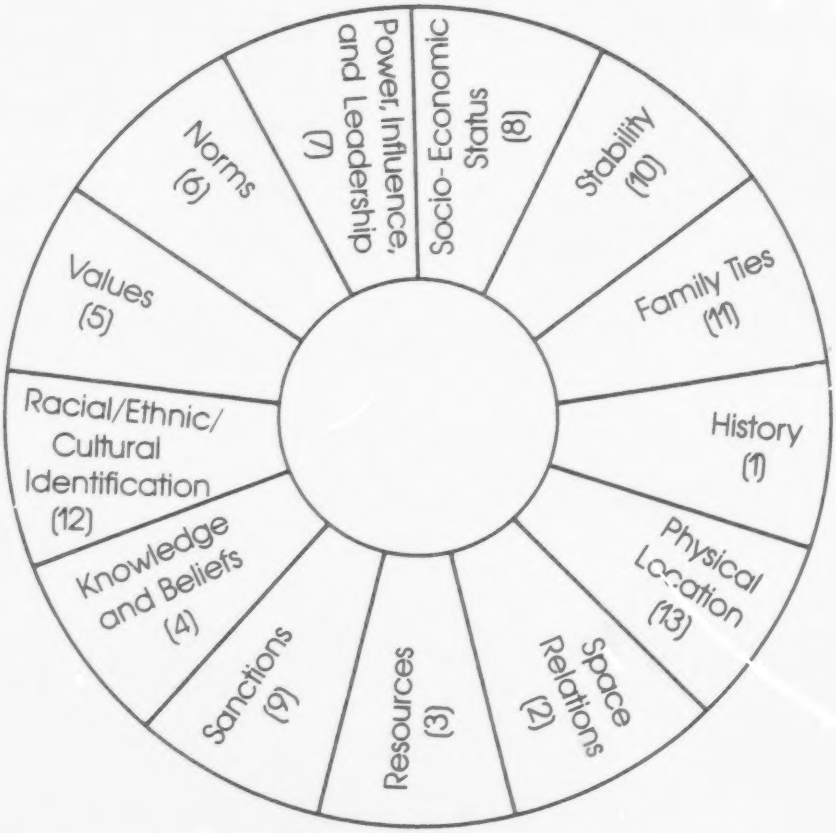
- Using individual worksheets, which correlate the 12 functions of the community with the CMA social compass, participants develop a data base for their own community (Worksheet IV-2, p. 97).

NOTE: Are all of these community functions applicable to each participant's community?

- Option: The trainer can also ask the participants to develop lists of the 10 most important:

TIME, MEDIA, AND MATERIALS	*OUTLINE OF TRAINING ACTIVITIES*
	- People - Places - Organizations - Favorite activities, etc. • Share in triads, with group members helping each other develop more information about their own communities. • Large group: Trainer processes participant responses, making trainees aware of what they know about their own communities, and what they need to learn. Points covered should include: - The information collected is part of the "needs assessment" process - The more you know about your community, the more able you are to develop a prevention program which meets that community's needs - The more resources of the community you can recognize, utilize, and develop, the better the program.
10 MINUTES	NOTE: Relate this discussion to the three themes emerging from the NIDA Prevention Delphi mentioned in Module III.
5 MINUTES	5. REVIEW/PREVIEW
	END OF MODULE IV

A Community Social Compass


History (1)
Space Relations (2)
Resources (3)
Knowledge and Beliefs (4)
Values (5)
Norms (6)
Power, Influence, and Leadership (7)
Socio-Economic Status (8)
Sanctions (9)
Stability (10)
Family Ties (11)
Racial/Ethnic/ Cultural Identification (12)
Physical Location (13)

LEGEND

1. History: History may be thought of as the "selective recording and interpretation of past elements." That is, you never learn about all of the previous activities in the life of a country or community; the causes and effects of past events are usually explained in one way or another.

   In reviewing the history of the community, we are concerned with:

   - Its official and more or less "objective" history as it may be given in public documents, etc.;
   - Its traditions or folk history as recounted by its residents.

   A preliminary study of the history of the community provides:

   - Background information needed to understand its present position and problems;
   - A widely acceptable means to show your respect for its people and their way of life;
   - An opportunity to meet a number of its key residents; and
   - Many insights into conflicting values, factions, etc.

2. Space relations: through this element we look at:

   - The internal relations within the community, its geographic area, and the disposition of its people, industry, social activities, etc.;
   - The external relations of the community with other communities in the vicinity and with the regional and national capitals, including the means of communication and transportation and the distances and time involved for each; and
   - The number and kinds of links that exist between this community and others through trade, marriage, etc.

3. Resources: The resources of a community are any aspects of its total environment which its people may use to meet their individual and shared needs. Such resources include the services available from government and private agencies. In assessing resources, the following subdivisions may be useful:

   - Human--the number of people and their capabilities, with allowances made for age, disease, malnutrition;
   - Man-made--such items as roads, communication media;
   - Natural--land, water, minerals, forests, sources of energy.

4. Knowledge and Beliefs: This element covers what is known and thought about the world, and life in it, and is thus related to technology, the use of resources, and goals.

   In belief there is an aspect of personal conviction which is absent from mere knowledge. It is therefore easier to change knowledge, on the whole, than to affect belief. On the other hand, a program linked to people's beliefs has a firmer foundation than one which is based upon items of information which they know, but do not particularly care about. Beliefs are linked with values and with sentiments.

5. Values: Values are essentially "ideals of the desirable" which are held by individuals; many values are shared by most of the people in the community and thus form the basis for predictable patterns of behavior.

6. Norms: Norms are the standards of what is right or wrong, good or bad, and appropriate or inappropriate in social life in the community. They form the "rules of the game" which indicate acceptable standards of conduct for every social situation. Norms are specific recommendations for behavior derived, like goals, from the values and sentiments of the people. Norms are enforced by various forms of social pressure in the community.

7. Power, Leadership, and Influence: Power describes the ability of one person to control others.

   The leadership positions in a community range from formally elected offices to the informal leadership. Leadership involves the ability to help a group make decisions and to act on them; it may include organizing people formally or informally. Remember that a leader is one who has followers--not all who act and sound like leaders actually have followers. Leadership capacity is indicated by the number and stability of a leader's following. Most leaders lead from in front; many other effective leaders prefer to lead from behind, quietly and almost unnoticed--don't overlook them!

   Influence is the ability to affect the behavior of others, often without their being fully aware of it.

   Note that while some people possess these capacities in most spheres of community life, others are effective in only one area; e.g., a woman may be a power figure, a leader or influential in matters of agriculture, but not in social or political life.

8. Socioeconomic Status: Social rank describes the standing that a person or group has in the community. It may depend largely on one's family and inherited characteristics, or it may rest upon the individual's personal achievements. The factors which determine who "rates" depend a good deal on the values which predominate in the pattern being considered.

9. Sanctions: These are the rewards and punishment which induce an individual to retain the goals and norms of the group. They help to assure the preservation of the group and its way of life by encouraging support for its values and sentiments, positions and roles.

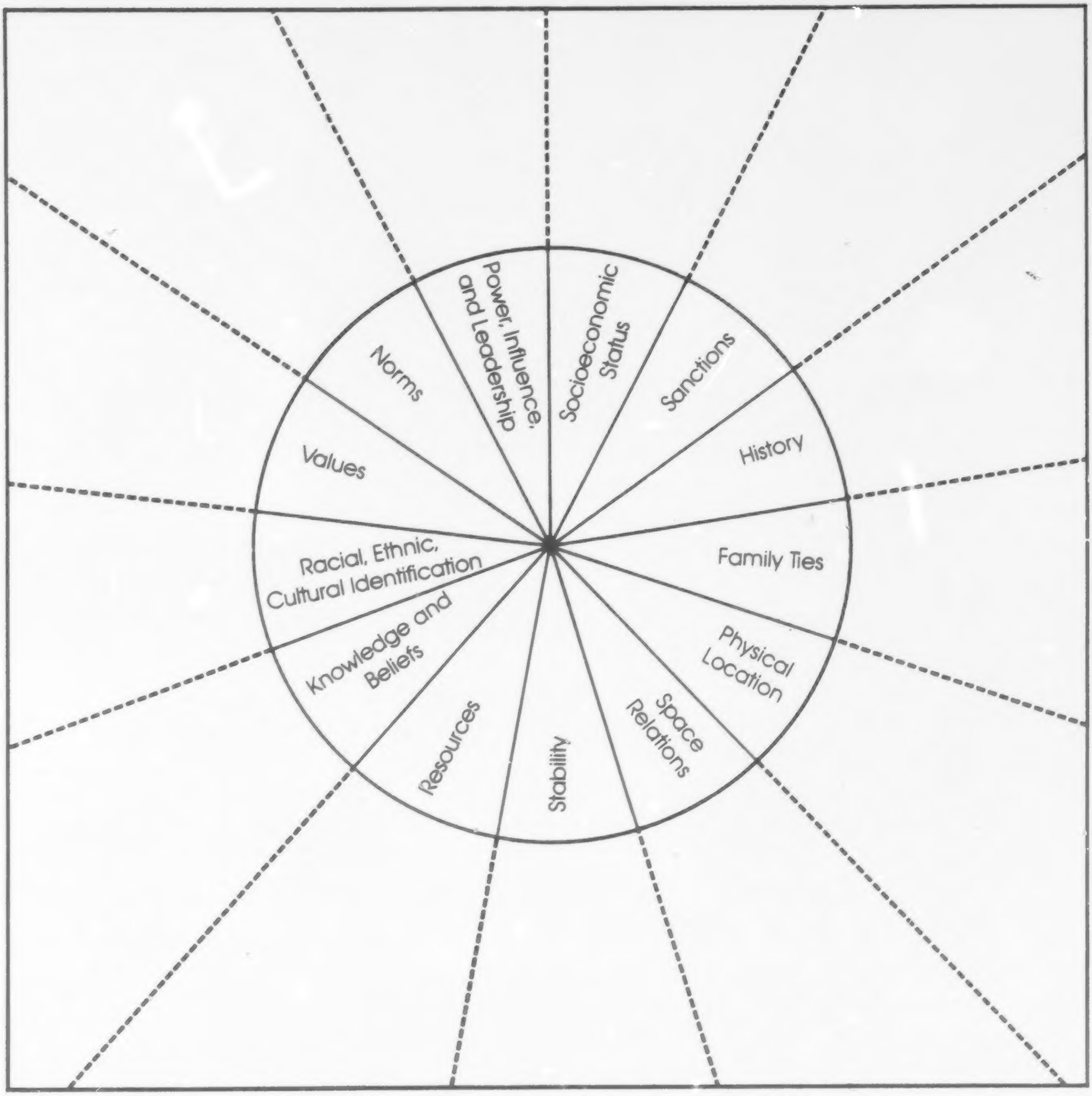
10. Stability: Stability is the degree to which a community remains constant in terms of its institutions, its members, and even its location. The stability of a community often determines the methods that must be used to address social problems. Many social problems are directly related to the lack of stability in a community.

11. Family Ties: The family ties that are common in any given community may range from the percentage of children without parents, to the frequency of extended family ties where three or even four generations live in the same household. The median is the standard two-parent family. Family intervention is one important means of addressing behavior problems in youth.

12. Racial/Ethnic/Cultural Identification: Many, if not most, communities are made up predominantly of one racial group. These racial groups vary in the degree of their identification with the cultural and historical past. For some communities, traditions actually form the base for that community and much of the other aspects of life are built around those traditions. Strict compliance with the traditions is a major factor for those groups. For other communities, the culture is scorned and looked down upon.

13. Physical Location: Physical location relates to the degree of isolation of a community. In many communities, isolation is a factor in determining many influential approaches to social problems. On one hand, isolated communities may not have a particular problem due to its isolation, but on the other hand, some problems that it does have can't be adequately addressed because of the lack of support services available to that community, due to its isolation.

CMA Social Compass


Norms
Power, Influence, and Leadership
Socioeconomic Status
Sanctions
History
Family Ties
Physical Location
Space Relations
Stability
Resources
Knowledge and Beliefs
Racial, Ethnic, Cultural Identification
Values

Adapted from Conner, Desmond M.: Understanding Your Community. Ottawa: Development Press, 1969.

MODULE IV: KNOWING YOUR COMMUNITY--2 **WORKSHEET**

Community Functional Areas

HOME 1	SCHOOL 2	CHURCH 3
NEIGHBORHOOD 4	HEALTH SERVICES 5	SOCIAL SERVICES 6
RECREATION AND LEISURE 7	BUSINESS AND INDUSTRY 8	JUSTICE AND SAFETY 9
LEGISLATURE 10	LOCAL GOVERNMENT 11	MEDIA 12

MODULE V

MODULE V: BEGINNING THE PLANNING PROCESS **TIME:** 3 HOURS

GOALS

- Provide participants with a conceptual framework for prevention planning and decision-making, as they begin to identify appropriate program objectives for their own communities.

OBJECTIVES

At the end of this module, participants will be able to:

- Identify and use available prevention needs assessment and planning resources
- Write one possible prevention program objective for their community.

MATERIALS

- Newsprint
- Magic Markers
- Paper
- Pencils
- Diagrams (Prevention Planning Functions; Needs Assessment Process)
- "Writing Program Objectives"

MODULE V OVERVIEW

EXERCISE	TIME	METHODOLOGY
1. THE PLANNING PROCESS	20 MINUTES	LECTURE/DISCUSSION
2. THE PREVENTION PLANNING MODEL	35 MINUTES	LECTURE/DISCUSSION
3. WRITING OBJECTIVES	45 MINUTES	INDIVIDUAL EXERCISE
4. COMPARING OBJECTIVES	30 MINUTES	LARGE-GROUP EXERCISE

MODULE V: BEGINNING THE PLANNING PROCESS

TIME, MEDIA, AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
20 MINUTES Outlined Lecture Notes Newsprint Magic Markers Paper	1. LECTURE/DISCUSSION: THE PLANNING PROCESS - Introduce the lecture/discussion by explaining that, after obtaining a basic understanding of how a community functions, the prevention specialist should begin planning his/her strategy, which identifies a specific community problem or a need for change. - Explain that this lecture/discussion will focus specifically on the planning process as a personal and administrative tool. - Explain the following short exercise on ordering planning activities. Script: Prior to introducing the planning process, we would like to take this opportunity to allow you to do a quick self-assessment on how you would order planning activities. First, how do you go about planning now? Please write down the steps that you use.
15 MINUTES	- Allow participants 10 minutes to complete this task. - Trainer asks volunteers to share their individual planning processes, noting the similarities/differences. NOTE: To lead into an explanation of the nine planning functions from the Prevention Planning Workbook, the trainer will record trainees' responses, grouping them in general categories that will be related to the planning model.
35 MINUTES Eight Planning Functions Diagram	2. LECTURE/DISCUSSION: THE PREVENTION PLANNING MODEL - Trainer introduces the eight planning functions of the Prevention Planning Model, as developed in the Prevention Planning Workbook (Figure V-1, p. 108).

NOTE: The trainer should remind participants that the materials developed through NIDA's Prevention Branch--The Prevention Planning Workbook, the Needs Assessment Workbook, CMA's Multicultural Workbook, and the National Prevention Evaluation Resource Network (NPERN) Guidelines--can serve as invaluable planning and program development tools. Our purpose in this training course is to make participants aware of these resources and encourage them to make use of the comprehensive information on planning, needs assessment, and evaluation that they contain.

- Trainer talks participants through the diagram of the Prevention Planning Process, relating each function to the individual participant's planning process components previously listed on newsprint.

30 MINUTES

Needs Assessment Diagram

- Needs Assessment: The trainer introduces the diagram of the Needs Assessment Process (Figure V-2, p. 109) from the Needs Assessment Workbook. Discuss the general steps in a needs assessment process, relating these steps to the information gathering that has been going on in earlier modules, e.g., the Social Compass exercise in Module IV.

- Refer participants to "Conducting a Community Assessment" in their manuals for a further look at needs assessment issues--correlate the diagram with Wheeler's descriptions of particular techniques.

NOTE: It is important to "demystify" terms like "needs assessment" and "evaluation" for beginning preventors. Remind participants that much of what they have done as a matter of course or intuition becomes streamlined into a "needs assessment process" or "planning process."

- Ask participants to review the planning steps that they previously recorded on paper and discuss these. The discussion should focus on the following:

- How does their planning process differ from the suggested model?
- Are any steps missing?
- How might these missing steps affect the success of their plans?
- What parts of planning do they find most difficult?
- Are there specific values or problems in their communities that might have an impact on planning and/or needs assessment?

NOTE: Be sensitive to ethnic or rural/urban differences.

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45 MINUTES

Self-Instructional Package: "Writing Specific Program Objectives"

3. EXERCISE: WRITING OBJECTIVES

- Inform the participants that they are about to participate in an individual learning program exercise. Writing objectives is critical to good planning, but because it is a skill that is unfamiliar to many people, this individual learning program exercise is included to give intensive instruction and practice.
- Refer participants to "Writing Specific Program Objectives" in the participant manual.
- Ask if anyone is familiar with programmed instruction. If one of the participants can explain how it is used, permit him/her to do so. Otherwise, give a brief explanation.
- Give instructions to the group as follows.

Script:

All information and directions are included in the program. Turn to the first page of the individual learning program. This page lists the objectives for the program. They specify what the learner will be able to do when he or she completes the individual learning program. Turn to next page of the individual learning program. If you think you can write

TIME, MEDIA, AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES

a specific, time-phased, measurable objective now, take the pretest and then have the leader check your answers. If you prefer to omit the pretest, turn to the third page and read and follow the directions. Take all the time you need, but work steadily. When you have completed the last page, check your answers with the trainer.

An objective is acceptable if you can find answers to all of these questions:

1. What will the result be?
2. How will it be measured?
3. When will it be accomplished?

See "Writing Specific Program Objectives" for an example.

- Facilitate the exercise.

- Summarize the exercise by discussing the limitations of specific objectives and raise some of the questions that should be asked about objectives. These are highlighted in the following points:

  1. Writing specific, measurable, time-phased objectives is important because this process forces us to think clearly about what it is we want to do and because it makes evaluation easier.

  2. An objective must pass other tests for acceptability:

     - Is it consistent with organization goals?

     - Is the outcome of the objective worth the time and effort required to achieve it?

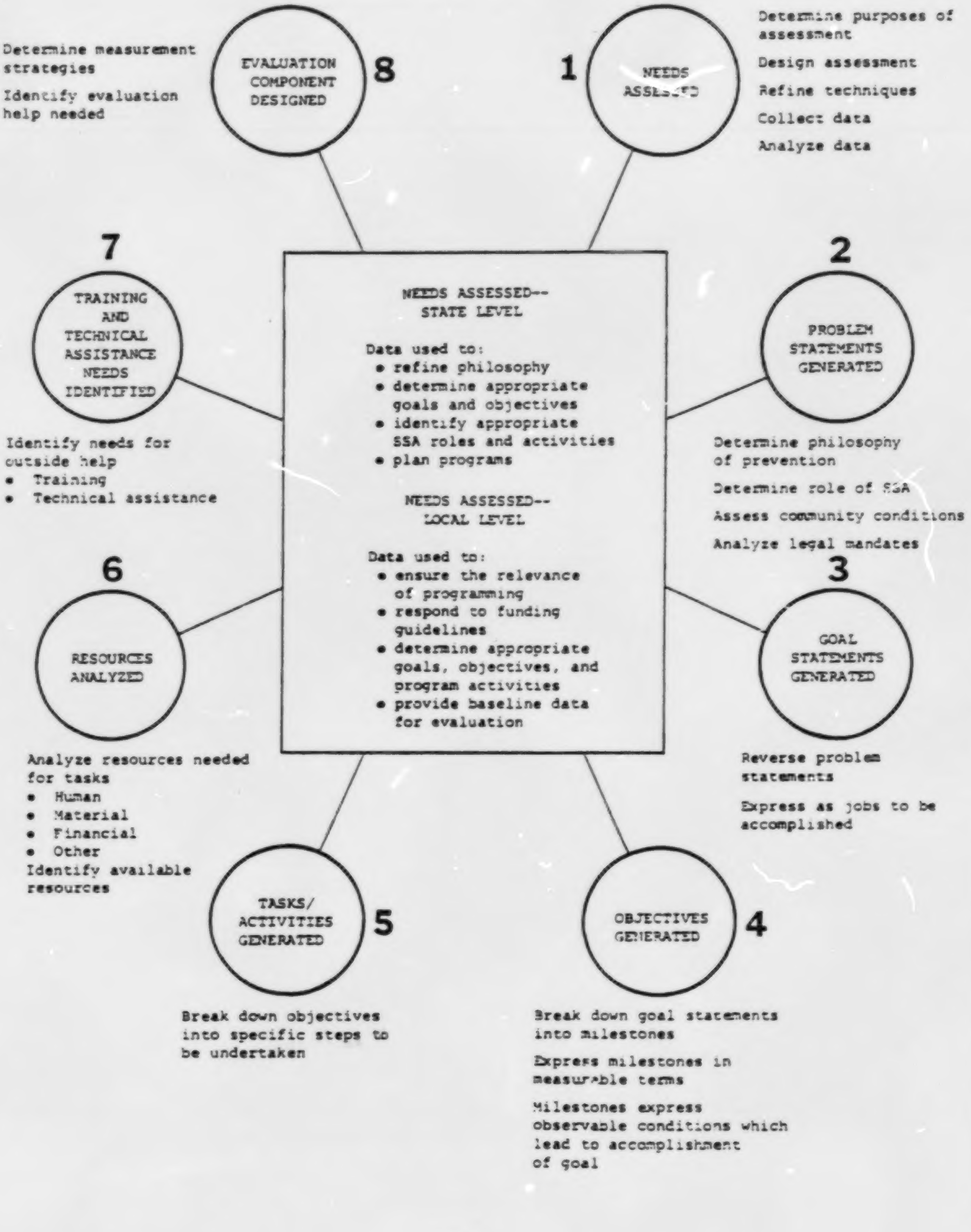
     - Can it be done?

     - Do we have the resources to do it?

     - What are the implications of achieving the objective?

TIME, MEDIA, AND MATERIALS	*OUTLINE OF TRAINING ACTIVITIES*
30 MINUTES	4. EXERCISE: COMPARING OBJECTIVES
Newsprint	• Trainer asks individuals to share their objectives, which the trainer records on newsprint. Discuss the range and emphasis of the objectives, including: - How many different approaches to prevention are represented? - Have people chosen similar objectives? NOTE: Mention possibilities for collaboration, team-building, as entry into material on networking presented in Module VIII.
10 MINUTES	• Wrap-up module, leading into discussion of community support in the next module by emphasizing that enlisting the support and resources of the community is essential in achieving any prevention programming objective.
	END OF MODULE V

FUNCTIONAL ANALYSIS
OF THE PREVENTION PLANNING PROCESS


1
NEEDS ASSESSED
2
PROBLEM STATEMENTS GENERATED
3
GOAL STATEMENTS GENERATED
4
OBJECTIVES GENERATED
5
TASKS/ ACTIVITIES GENERATED
6
RESOURCES ANALYZED
7
TRAINING AND TECHNICAL ASSISTANCE NEEDS IDENTIFIED
8
EVALUATION COMPONENT DESIGNED

NEEDS ASSESSED--
STATE LEVEL

Data used to:
- **refine philosophy**
- **determine appropriate goals and objectives**
- **identify appropriate SSA roles and activities**
- **plan programs**

NEEDS ASSESSED--
LOCAL LEVEL

Data used to:
- **ensure the relevance of programming**
- **respond to funding guidelines**
- **determine appropriate goals, objectives, and program activities**
- **provide baseline data for evaluation**

Determine purposes of assessment

Design assessment

Refine techniques

Collect data

Analyze data

Determine philosophy of prevention

Determine role of SSA

Assess community conditions

Analyze legal mandates

Reverse problem statements

Express as jobs to be accomplished

Break down goal statements into milestones

Express milestones in measurable terms

Milestones express observable conditions which lead to accomplishment of goal

Break down objectives into specific steps to be undertaken

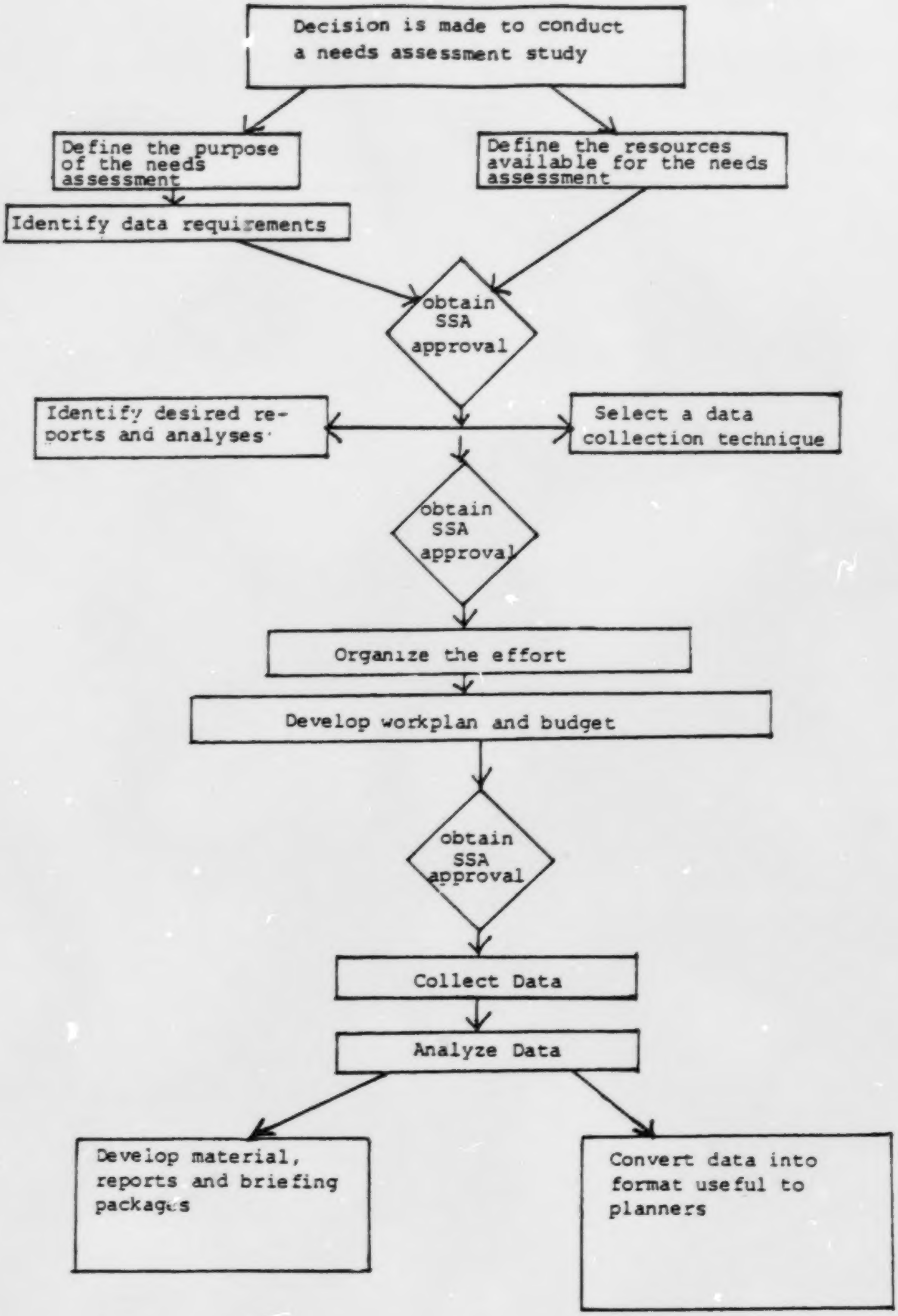
Analyze resources needed for tasks
- Human
- Material
- Financial
- Other

Identify available resources

Identify needs for outside help
- Training
- Technical assistance

Determine measurement strategies

Identify evaluation help needed


Decision is made to conduct a needs assessment study
Define the purpose of the needs assessment
Define the resources available for the needs assessment
Identify data requirements
obtain SSA approval
Identify desired reports and analyses
Select a data collection technique
obtain SSA approval
Organize the effort
Develop workplan and budget
obtain SSA approval
Collect Data
Analyze Data
Develop material, reports and briefing packages
Convert data into format useful to planners

MODULE VI

MODULE VI: DEVELOPING COMMUNITY SUPPORT FOR PREVENTION **TIME:** 3 HOURS

GOALS

- Assist participants in identifying critical elements in developing a broad base of community support for their prevention programs
- Write an action plan for achieving this goal.

OBJECTIVES

At the end of this module, participants will be able to:

- List five factors that promote the acceptance of drug abuse prevention efforts in their communities
- List five factors that hinder prevention efforts in their communities
- Write an action plan for creating community support
- List at least three criteria for success in their efforts to build community support for prevention.

MATERIALS

- Newsprint
- Magic Markers
- Pencils
- "Helping/Hindering Factors" Worksheet
- CBPS Action Plan Workbook

MODULE VI OVERVIEW

EXERCISE	TIME	METHODOLOGY
1. INTRODUCTION: PREVIEW OF COURSE	5 MINUTES	DISCUSSION
2. THE IMPORTANCE OF COMMUNITY SUPPORT	10 MINUTES	LECTURE/DISCUSSION
3. HELPING/HINDERING FACTORS	45 MINUTES	INDIVIDUAL EXERCISE
4. BUILDING SUPPORT FOR DRUG ABUSE PREVENTION	45 MINUTES	SMALL-GROUP EXERCISE
5. ACTION PLANNING	2 HOURS	INDIVIDUAL EXERCISE

5 MINUTES

1. INTRODUCTION: REVIEW OF COURSE

- Review course to date. Participants have begun to identify their own strengths as preventors (as well as their view of prevention), assess the strengths and resources of their own communities, and develop a tentative program objective.

---

10 MINUTES

2. LECTURE/DISCUSSION: THE IMPORTANCE OF COMMUNITY SUPPORT

- The trainer discusses the need for involving the community in the planning and development of a prevention program. The community is the source of:

  1. Resources: volunteers, funds
  2. Participants
  3. Publicity
  4. Program sites
  5. Other public and private social services.

Trainer can give examples from his/her own experience or elicit examples from the trainees.

---

45 MINUTES

Newsprint

3. EXERCISE: HELPING/HINDERING FACTORS

- Trainer introduces the force-field analysis exercise.

Script:

Any individual, agency, or institution can be considered as a dynamic balance of forces working in opposite directions. No change will take place within the agency unless an imbalance in these forces is created to upset the equilibirum. A method of planned change, based on this theory of opposing forces, was developed by a Social psychologist, Kurt Lewin, and is called force-field analysis.

Forces moving towards change, helping forces, are opposed by an equal number of forces against change, hindering forces. An analysis to discover the existing helping and hindering forces will reveal alternative means of creating an imbalance, thus creating change. The concept involves identifying the primary goal that the group and/or individual wishes to achieve, e.g., developing a drug education program for elementary school children.

Planned Change: Lewin states that change can be planned by analyzing the helping and hindering forces--the concept of force-field analysis--and that change can occur through any of the following:

1. Changing the strength of any force
2. Changing the direction of any force
3. Adding new helping forces
4. Eliminating hindering forces.

Process of change: With the preceding in mind, one approach to the process of change is to work through the following steps:

"Helping/Hindering Forces" Worksheet

1. List the present helping and hindering factors (Worksheet VI-1)
2. Identify those helping factors that can be strengthened or new ones which may be added, and the actions which will bring this about
3. Identify those hindering forces which can be weakened, redirected, or eliminated, and the actions which will bring this about
4. List resources which will assist in this process.

---

45 MINUTES

4. EXERCISE: BUILDING SUPPORT FOR DRUG ABUSE PREVENTION

Newsprint

- First, in small groups, ask participants to brainstorm a list of factors that help and factors that hinder the development of effective drug abuse prevention programs in their communities (Worksheet VI-1, p. 102).
- Second, in the large group, compile a master list of those helping and hindering factors. Then, select one of the helping factors and one of the hindering factors and brainstorm strategies for using each of those factors to achieve your goal of building community support, i.e.,

TIME, MEDIA, AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
	how you can use the helping factor of "strong civic pride" to enhance drug abuse prevention activities? Or, how can you overcome "high unemployment" to build a drug abuse prevention program? NOTE: The lists of helping and hindering factors will usually contain a mixture of causal factors, i.e., those conditions that may contribute to the drug abuse problem, and factors which impede the development of a prevention program, e.g., no interagency cooperation. Both sets of factors can stimulate discussion around building community support; it may be important to point out that distinction to the training audience. You should also be aware of, and point out differences based on, rural or ethnic factors, as well as distinctions between preventor and community assumptions. (For example, in rural communities, geographic distance may be seen as an obstacle to the preventor but as a major source of pride to community members.) • Trainer concludes the discussion of helping and hindering factors by reminding participants that building community support is the key to realizing your prevention program objectives. Next, participants will begin to develop an action plan to mobilize community support for their particular program objective they wrote in Module V.
2 HOURS CPBS Workbook	5. EXERCISE: ACTION PLANNING • Use the "CBPS Action Plan Workbook." The steps outlined in the workbook are standard elements of the planning process. Action planning serves to provide a framework for effecting change in a program's structure, process(es), or function(s). The workbook forces participants to consider the conditions, constraints, resources, and limitations they will face in implementing these changes.

NOTE: Relate steps of action plan back to overall prevention planning process (nine functions) in Module V.

- Stress the following points:

Script:

This course has dealt with information and skills that will help prevention specialists/coordinators fulfill their roles. Information covered was relevant to defining the problem, assessing the prevention specialist's role, reviewing prevention programming, examining the community and program planning, program initiation strategies, resources, and evaluation.

Much of this information has been given in hypothetical form. You now have time to apply this information to a problem related to the operation of your program.

- Ask participants to locate the "CBPS Action Plan Workbook," in their Participant Manuals.

- Review the section titled "Action Plan Outline" before reviewing the "Action Planning Example: The Six Action Planning Steps for Program Implementation."

NOTE: We are asking trainees to use this generic planning tool to work toward the goal of mobilizing community support for their program objectives.

- Emphasize that participants should attempt to complete the Action Plan Workbook within the allotted time (2 hours).

- Advise participants that they may work individually or in small groups (if they are from the same program and choose to work on the same problem).

NOTE: During this exercise, provide individual consultation and technical assistance as needed.

TIME, MEDIA, AND MATERIALS	*OUTLINE OF TRAINING ACTIVITIES*
	• Ask participants to stop working at the end of the 2-hour period. • Answer any questions participants might raise concerning the task. • Reading assignment: community support readings.
	END OF MODULE VI

HELPING/HINDERING FORCES

	HELPING FORCES	HINDERING FORCES
INDIVIDUAL		
ORGANIZATION		
COMMUNITY		

MODULE VII

MODULE VII: GETTING THE NEWS OUT

TIME: 3½ HOURS

GOALS

- Familiarize participants with the concepts of formal and informal communications networks
- Assist them in developing realistic strategies for utilizing those networks within their own communities.

OBJECTIVES

At the end of this module, participants will be able to:

- Define formal and informal communications networks and differentiate between the two
- Identify the significant formal and informal communications networks within their own community
- List at least three strategies for utilizing their community information dissemination networks to develop drug abuse prevention activities
- Develop a media piece appropriate to their own program objectives.

MATERIALS

- Newsprint
- Magic Markers
- Pencils
- Daily newspaper

MODULE VII OVERVIEW

EXERCISE	TIME	METHODOLOGY
1. INTRODUCTION: REVIEW	10 MINUTES	LECTURE
2. WHAT'S THE BUZZ?	20 MINUTES	SMALL-GROUP EXERCISE
3. FORMAL AND INFORMAL COMMUNICATIONS NETWORKS	15 MINUTES	LECTURE/DISCUSSION
4. IDENTIFYING INFORMAL COMMUNICATIONS NETWORKS	30 MINUTES	INDIVIDUAL EXERCISE
5. FORMAL COMMUNICATIONS NETWORKS	30 MINUTES	LECTURE/DISCUSSION
6. USING YOUR MEDIA	20 MINUTES	SMALL-GROUP EXERCISE
7. FORMAL COMMUNICATIONS NETWORKS	30 MINUTES	LECTURE/DISCUSSION
8. MAPPING YOUR FORMAL COMMUNICATIONS NETWORK	30 MINUTES	EXERCISE
9. DEVELOPING A MEDIA PIECE	1 HOUR	SIMULATION
10. MOBILIZING THE COMMUNITY	30 MINUTES	LECTURE/DISCUSSION
11. BUILDING YOUR COMMUNITY GROUP	15 MINUTES	SMALL-GROUP EXERCISE
12. WRAP-UP	15 MINUTES	LECTURE

TIME, MEDIA, AND MATERIALS	*OUTLINE OF TRAINING ACTIVITIES*
10 MINUTES	1. INTRODUCTION: REVIEW The previous module discussed the importance of building community support for prevention programs, and participants began to develop an action plan towards achieving a particular objectives within their own community. NOTE: One strategy for introducing the discussion of communications networks within the community would be to ask participants if the activities in their action plans included any information dissemination activities, media work, or public education efforts. If so, list those tentative strategies on newsprint, pointing out the importance of communication in building prevention programs as well as ensuring the success of programs once established. The basic fear of the program developer is, "What if I gave a program and nobody came?"
20 MINUTES	2. EXERCISE: "WHAT'S THE BUZZ?" The purpose of this introductory exercise is to begin to stimulate the trainees' awareness of the incredible variety of communications sources that can be used in prevention programs and messages. In small groups, participants generate lists of sources of information within their own communities, perhaps creating a competition for the longest list.
15 MINUTES	3. LECTURE/DISCUSSION: FORMAL AND INFORMAL COMMUNICATIONS NETWORKS Script: Informal--All personal and professional contacts can be considered as components of your own informal network--where do you get your information from? This network includes other programs dealing with similar clients, other members of social and civic organizations, neighbors, and friends. You are constantly representing your program (and drug abuse prevention) and communicating information to others.

TIME, MEDIA, AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES

It is important to know your community well enough to pinpoint those groups/agencies that attract large numbers of people, particularly members of the target group that constitute the focus of your prevention efforts.

In some communities, the social center may be the churches. In rural areas, too, farmers' co-ops, granges, and even the local feed store may be the center of the informal communications network for that community. In inner-city areas, it might be a pool room, rec center, bar, or even a particular street corner. For young people, the focal point might be a park where they gather after school. Getting to know these areas will be important: once you've got your message, you need to know where to send it.

Key people are important to both formal and informal communications networks. Again, the characteristics of these influential individuals will vary from one community to another, and differ from one target group to another. It is important to remember that key people such as elected officials, principals, and police directors are not necessarily the most visible people. Often the people with the strongest and most direct lines of communication to the largest segment of the population keep a much lower profile. For example, in some rural areas, the veterinarian is a key person because he/she keeps the geographically isolated members of a community informed about what's going on. In some neighbordhoods, it's the woman who's "everybody's mother," whose house is the jumping-off point for all of the kids in surrounding blocks.

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30 MINUTES

4. EXERCISE: IDENTIFYING INFORMAL COMMUNICATIONS NETWORKS

- Individuals take out their community profiles from Module IV. Trainer asks them to look over their lists of significant community functions, as well as the data gathered on their social compasses for their own communities.
- Individual writing: beside each community function, list the components of an informal communications network that is formed around

that particular function (e.g., home: telephone calls, neighbors stopping in, the mailman stopping by, bridge clubs, poker games, kids gathering to watch TV, etc.)

- Small-group discussion: individuals compare their worksheets, generating additional ideas and identifying similarities and differences in the networks as perceived by the trainees.
- Large group: trainer processes the information, remembering to be aware of differences among different ethnic representatives, rural trainees, etc. The emphasis should be the variety and range of information channels within a community, any of which may be utilized to develop or disseminate prevention program information.

30 MINUTES

5. LECTURE/DISCUSSION: FORMAL COMMUNICATIONS NETWORKS

Script:

Formal networks are usually comprised of the more conventional communications media, such as television, radio, newspapers, and limited-circulation publications.

Again, know your community: what stations have the largest listening/viewing audience? Which news programs and talk shows are most popular? Watch and/or listen regularly to comprehend the particular points of view, pet projects, or editorial emphases of different news media. Read your newspaper--it's a wealth of information about the people, places, and events in your community--many of which may be important to the success of your prevention program.

20 MINUTES

6. EXERCISE: USING YOUR MEDIA

- Trainer hands out sections of the local newspaper for that particular day. Each small group (4-6 people) is assigned the task of selecting a particular article in their newspaper

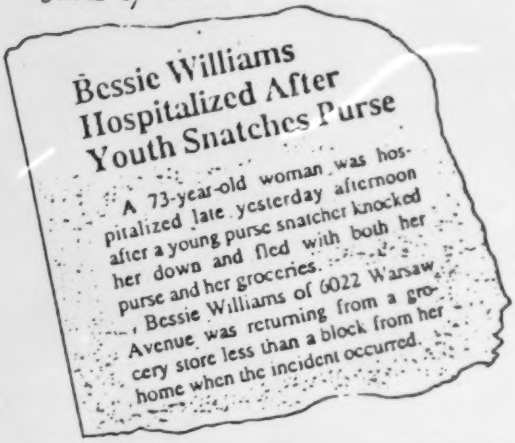
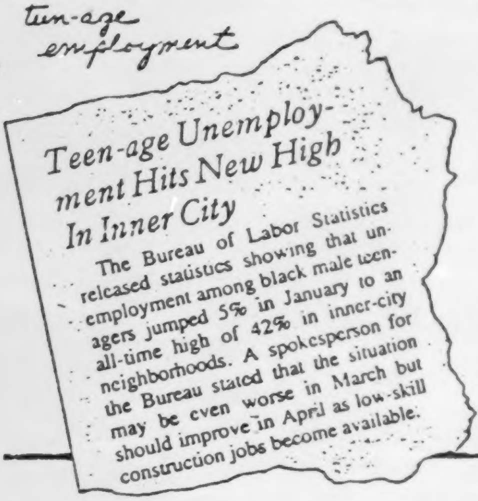
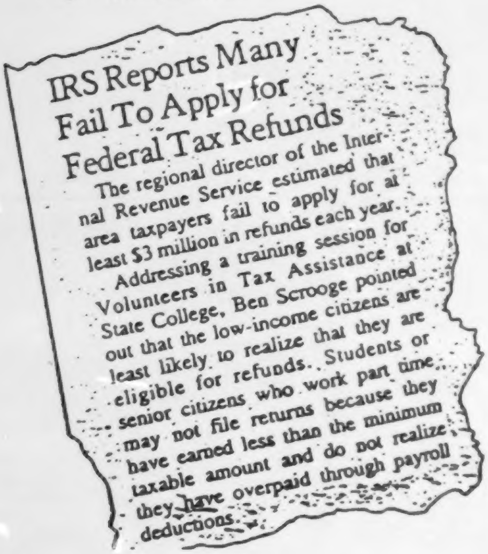
TIME, MEDIA, AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
	that might contain a possible "lead" for developing good prevention programs (see examples, Reference VII-I, p. 131). ● In small groups, trainees brainstorm possible efforts to address the problem or issue identified in the newspaper article. Then, the group lists actions to be taken to implement a particular possible strategy. ● Trainer processes the exercise in the large group, relating the exercise not only to communications efforts, but also to the needs assessment activity involved in this exercise.
30 MINUTES	7. LECTURE/DISCUSSION: FORMAL COMMUNICATIONS NETWORKS (Continued) Don't overlook the small publications, including suburban weekly newspapers, shoppers' guides. Pay attention to newsletters and bulletins circulated by civic organizations and special-interest groups (e.g., PTA's, neighborhood associations, garden clubs, the League of Women Voters, the political parties). Don't forget church bulletins. Resource: In each state, the telephone company prints a media directory that is separate from the regular directory--call your local business office and get a copy.
30 MINUTES	8. EXERCISE: MAPPING YOUR FORMAL COMMUNICATIONS NETWORK ● Individual writing: List all of the formal communications channels available in your community, breaking them down into categories: - Newspapers--Daily - Newspapers--Weekly - Special Publications - TV Stations - Radio Stations

MODULE VII: GETTING THE NEWS OUT

TIME, MEDIA, AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
1 HOUR	9. SIMULATION: DEVELOPING A MEDIA PIECE • In small groups, participants will be given the task of designing a 60-second TV or radio spot to use for Drug Abuse Prevention Week--1981. • Each group will have 30 minutes to develop a media spot. Use guidelines from "Broadcasting and Broadcasters" in the Participant Manual. • Each group will present its piece, in whatever way its members choose, to the large group. NOTE: If you choose, you may develop a mechanism for judging the pieces and selecting a prize piece. You may ask the group to rate the presentations; the trainer group might act as judges; a media resource person may also be involved in this module and asked to evaluate the pieces.
30 MINUTES Readings in Participant Manual	10. LECTURE/DISCUSSION: MOBILIZING THE COMMUNITY Script: Once the news is out and you've begun to develop a community base and/or community constitutency for your prevention efforts, the question then becomes, how can you most effectively channel that community interest so as to maximize your program's success? Once you have a solid understanding of the makeup of your community--its key people, places, and power points--and its media (formal and informal) capabilities, you can begin organizing those community resources to build your prevention program. Script: Whichever group you choose, it's important that you first have clearly in mind what your specific goals and objectives for that group are. Remember: people will be giving you a very precious commodity--their time and talent. Don't waste it. Provide them with a statement of their initial purpose and get group commitment of that goal.

MODULE VII: GETTING THE NEWS OUT

TIME, MEDIA, AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
15 MINUTES	11. EXERCISE: BUILDING YOUR COMMUNITY GROUP • Individual writing: Trainer asks individuals to refer back to their tentative program objective, and list individuals and/or organizations that might be possible participants in a group effort to address that particular objective.
15 MINUTES	12. WRAP-UP • Trainer reviews the material covered in the module, both the general concepts of utilizing formal and informal communications networks (through media campaigns as well as community involvement efforts), and the specific exercises in which they applied those concepts to their own community needs and programs. • Preview: The concepts of community council/ task force development anticipate the theoretical model of networking, which assumes that when people work together for common purposes they get there faster, quicker, and cheaper, and also have more fun along the way.
	END OF MODULE VII

Needs	Brainstorming	Action(s) Planned
Crime prevention  **Bessie Williams Hospitalized After Youth Snatches Purse** A 73-year-old woman was hospitalized late yesterday afternoon after a young purse snatcher knocked her down and fled with both her purse and her groceries. Bessie Williams of 6022 Warsaw Avenue was returning from a grocery store less than a block from her home when the incident occurred.	Vigilante force to patrol Deliver groceries to elderly Ask Department of Human Resources to provide vans or cabs Use school bus to take elderly shopping once a week Go to stores with elderly shoppers	Set up escort service for elderly citizens
teen-age employment  ***Teen-age Unemployment Hits New High In Inner City*** The Bureau of Labor Statistics released statistics showing that unemployment among black male teenagers jumped 5% in January to an all-time high of 42% in inner-city neighborhoods. A spokesperson for the Bureau stated that the situation may be even worse in March but should improve in April as low-skill construction jobs become available.	Join the Army Set up a business staffed by teenagers Give workshops on job hunting-- where to look, how to fill out applications, being interviewed Write letters to biggest employers asking them to hire teen-agers	Setup a job bank for teen-agers; require all who register to take part in a workshop on job hunting
Tax assistance  **IRS Reports Many Fail To Apply for Federal Tax Refunds** The regional director of the Internal Revenue Service estimated that area taxpayers fail to apply for at least $3 million in refunds each year. Addressing a training session for Volunteers in Tax Assistance at State College, Ben Scrooge pointed out that the low-income citizens are least likely to realize that they are eligible for refunds. Students or senior citizens who work part time may not file returns because they have earned less than the minimum taxable amount and do not realize they have overpaid through payroll deductions.	Give course on filing for refunds Interview students who wish to make sure they are filing Put up posters in schools and senior centers telling people to file Set up free tax advisory service	Write IRS to set up VITA training course

"A Nose for Needs"
FROM SYNERGIST,
SPRING 1979,
NSVP, Washington,
D.C.
20525

MODULE VIII

MODULE VIII: NETWORKING AND RESOURCE BUILDING **TIME:** 3 HOURS

GOALS

- Provide participants with a conceptual understanding of "networking"
- Enable them to identify potential community resources
- Assist them to formulate an action plan to develop a school-based prevention program in their own community.

OBJECTIVES

At the end of this module, participants will be able to:

- Define and explain the concepts of networking
- Identify six community agencies with whom they could develop a network for prevention
- Identify personal, organizational, and community resources for prevention programs
- Identify basic resource materials and sources of technical assistance for prevention programs.
- Define and explain the concepts of process outcome and impact evaluation as defined in the NPERN guidelines.

MATERIALS

- Newsprint
- Magic Markers
- "Broken Squares" Game
- Participant action planning worksheets (from other modules)
- Reference materials
    - "Networks: A Key to Person-Community Development," by Anne Dosher, Ph.D.
    - "Make a Network" worksheets
    - "A Basic Prevention Library"

MODULE VIII OVERVIEW

EXERCISE	TIME	METHODOLOGY
1. NETWORKING	30 MINUTES	LECTURE/DISCUSSION
2. APPLY NETWORKING TO DEVELOPING PREVENTION PROGRAMS	30 MINUTES	SMALL-GROUP EXERCISE
3. BROKEN SQUARES GAME	35 MINUTES	INDIVIDUAL EXERCISE
4. TRAINER WRAP-UP	10 MINUTES	LECTURE
5. PERSONALIZING THE THEORY	15 MINUTES	INDIVIDUAL EXERCISE
6. BUILDING RESOURCES	20 MINUTES	LECTURE/DISCUSSION
7. PLUSES AND WISHES	15 MINUTES	INDIVIDUAL EXERCISE
8. FINDING RESOURCES	20 MINUTES	LECTURE/DISCUSSION
9. AND A GOOD WORD ABOUT EVALUATION	30 MINUTES	LECTURE/DISCUSSION

MODULE VIII: NETWORKING AND RESOURCE BUILDING

TIME, MEDIA, AND MATERIALS

OUTLINE OF TRAINING ACTIVITIES

30 MINUTES

Networking references

1. LECTURE/DISCUSSION: NETWORKING (based on Anne Dosher)

Script:

The idea of network and networking is basic to those of us who have been working in communities and movements over the decades, since organizing is the process of bringing together various elements in order to develop a whole from a combination of nodes (people, groups, organizations, systems) for a common purpose. We develop networks as ongoing organizations and carefully tend the three variables of:

1. Nodes of the network (people, organizations, systems)
2. Information flow (feelings, facts, data)
3. Linkages (pathways for information).

TYPES OF NETWORKS:

1. Person-Family Network
2. Organizational Network
3. Interorganizational Network
4. Human Service Networks.

Networks are intended to be "process-oriented, member-supportive, decentralized learning systems."

FUNCTIONS OF A NETWORK:

1. Communication linkages and information channels
2. Participants support systems and resource sharing
3. Means for coordination, collaboration, person/program actualization, training, and capacity-building
4. Means for collective action.

ROLES essential to the design, creation, negotiation, and management of networks include:

TIME, MEDIA, AND MATERIALS	*OUTLINE OF TRAINING ACTIVITIES*
	• Systems negotiators • Underground managers • Maneuverers • Brokers • Managers • Facilitators. SKILLS include: • Interpersonal communications • Group process • Organizational development and management • Negotiation • Mobilization • Planning • Change process conceptualization.
Diagrams	• For a model of a typical network, see Anne Dosher's diagram (Figure VIII-1, p. 143).
30 MINUTES	2. EXERCISE: APPLY NETWORKING TO DEVELOPING PREVENTION PROGRAMS • Trainees form 3 small groups to brainstorm possible applications of networking theory to community prevention efforts. One trainer should facilitate each group. - Specific objectives of networking - Possible members of such a network. • Report out--groups share their conclusions; trainer processes the suggestions generated by the groups.
35 MINUTES	3. EXERCISE: THE BROKEN SQUARES GAME • Each participant is given an envelope that contains pieces of cardboard for forming squares. When the facilitator gives the signal to begin, the task of each group is to form five squares of equal size. The task will not be completed until each individual has before him a perfect square of the same size as those in front of the other group members. Specific limitations are imposed upon your group during this exercise.

1. No member may speak

2. No member may ask another member for a piece or in any way signal that another person is to give him a piece. (Members may voluntarily give pieces to other members.)

NOTE: An option is to leave one piece out of each set of 5 packets. When the group recognizes that a piece is missing, and so informs the trainer, they would be given the piece. Processing this option would include discussion of:

- Not having enough resources to do the work
- Understanding the limitations of your situation.

DISCUSSION:

Trainer processes the feelings that emerge in the course of the exercise--of frustration, isolation, anger, impatience, relating them to the realities of doing drug abuse prevention--obstacles to program goals, being the only person in your community interested in prevention, etc. Allow participants to explore possible relationships between their own experiences and the exercise:

1. Have they had similar feelings in the course of their professional lives?

2. How have they handled those feelings in the work environment?

20 MINUTES

NOTE: Relate these feelings to the need for a personal and professional support system in which these feelings can be processed and alleviated. Opportunities may be arising within the training for the creations of networks within the training population, e.g., individuals from similar communities, with similar program objectives, or who seem to have "hit it off" in the course of the training. Encourage those individuals to make commitments to build a mutual support system after the conclusion of the training...perhaps allowing an opportunity for individuals who desire to contract with each other around networking.

---

10 MINUTES

4. TRAINER WRAP-UP

- In summarizing networking as a possible collaborative strategy to help develop and institutionalize drug abuse prevention programs as well as a personal growth, survival, and support strategy for preventors, remind participants that:
  - They need to know why they're networking
  - They need to attend to the possible benefits of that effort relative to the time and energy invested in creating and maintaining
  - Networking, like all other techniques, must be considered and evaluated in terms of the ends of your program--will it get you closer to where you want to go?

---

15 MINUTES

5. EXERCISE: PERSONALIZING THE THEORY--CREATING NETWORKS IN OUR OWN COMMUNITIES

- Instructions: Trainers ask participants to begin thinking about individuals and organizations, within their own school/community environment, whom they might include in a networking effort toward community-based prevention programs (see Worksheet VIII-1, p. 144).

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20 MINUTES

6. LECTURE/DISCUSSION: BUILDING RESOURCES

Script:

The concept of networking is based upon the need to maximize program resources in all of the human service delivery systems--given the financial climate of the times, we need to continue to do more with less. Often, however, we neglect to see how much we really have already built into that "less" we're dealing with. For example, we have spent a great deal

TIME, MEDIA, AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
	of time looking at what's going on within communities and identified a great deal of activity, talent, and energy in each of your communities. What we need to do is to realize that those resources are waiting for us to tap them.
15 MINUTES "Pluses and Wishes" Worksheet	7. EXERCISE: "PLUSES AND WISHES" • Individual writing: trainer asks individuals to complete the "Pluses and Wishes" worksheet (Worksheet VIII-2, p 145), thinking carefully about the strengths and resources that already exist--at personal, organizational and community levels--and consider what he/she would like to introduce (in other words, what resources does he/she need as a preventor? does the organization need? the community need?) • Share in small groups, assisting each other in adding to the strengths and resources lists.
20 MINUTES	8. LECTURE/DISCUSSION: FINDING RESOURCES • Using the Basic Prevention Library, the trainer makes participants aware of the myriad of resources available, being sure to emphasize that, right within the training room, are your most available resources--personal contacts with people who believe in the same endeavor. NOTE: If the State Prevention Coordinator is a part of the training team, or available to act as a resource during this module, he/she can be invaluable in informing participants about State grant programs, any support networks existing with the State, and other State-developed courses/program options. Also note the variety of technical assistance options available through NIDA contractors--such as Pyramid, CMA, NDACTRD, RSCs, and NPERN.

TIME, MEDIA, AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
30 MINUTES	9. LECTURE/DISCUSSION: ...AND A GOOD WORD ABOUT EVALUATION

- The emphasis of the course is on getting prevention programs started, highlighting the needs assessment, community organization, and planning components of doing drug abuse prevention. It is critical, however, that your planning includes attention to evaluation issues from the start.

- The NIDA Prevention Model: NPERN Guidelines

  The trainer introduces participants to the components of the NIDA prevention model, defining process, outcome and impact evaluation, and then refers individuals to the reference materials in the Participant Manual.

- You're already on the road to developing an evaluation component: Trainer reminds participants that the cornerstone for an evaluation plan for their program is contained within the planning activities they've been engaged in for the duration of this training:

  - Their needs assessment activities
  - Formulation of program objectives
  - Development of an action plan

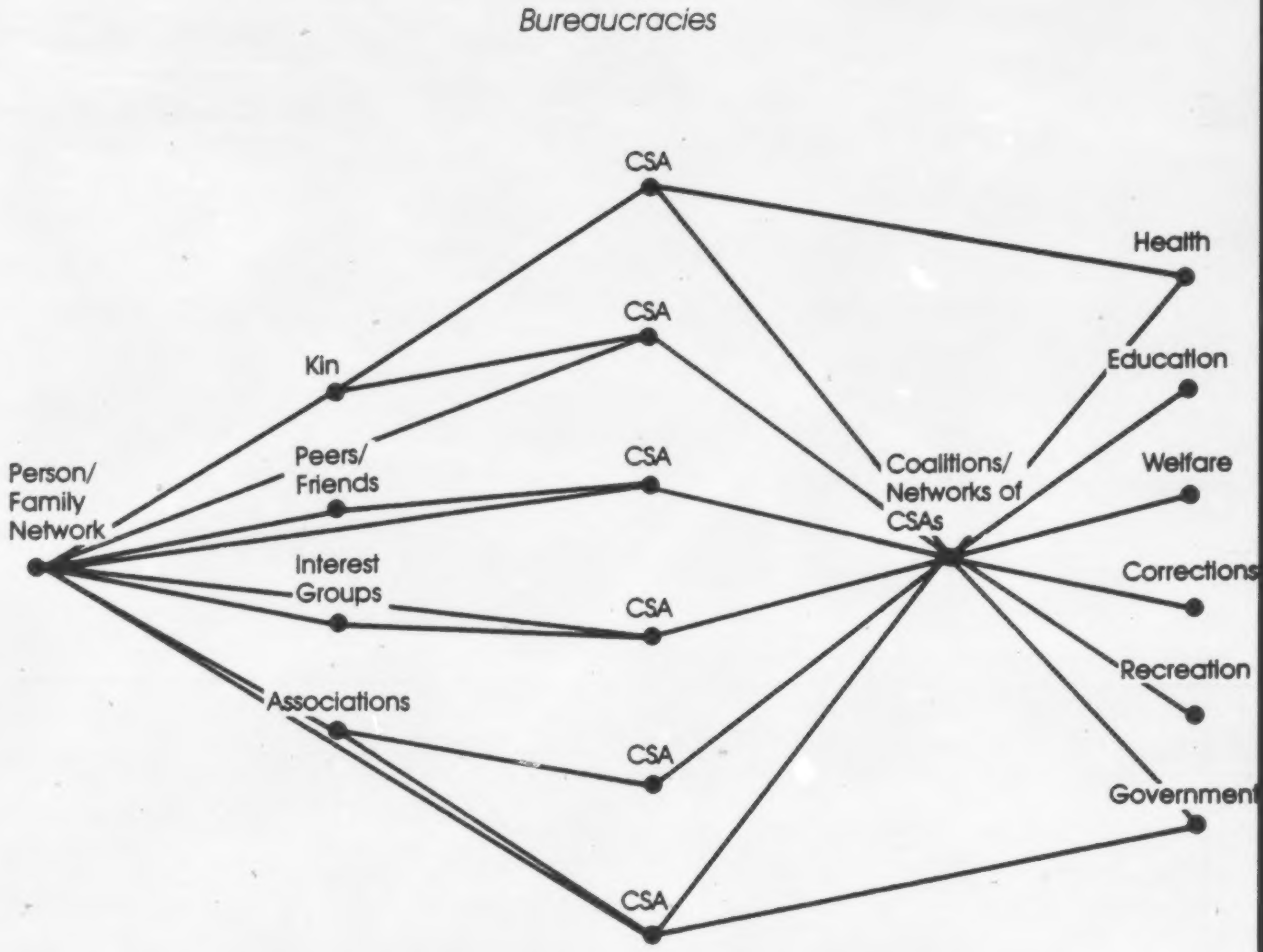
  All of these are the raw materials around which one develops evaluation.

- Trainer encourages participants to see evaluation not as someting to be afraid of, but as an opportunity to learn about the strengths of your program and upon which you can build better programs.

  "Evaluation, like commencement, is the conclusion of one journey and the beginning of another."

  - (Koberg & Bagnall, The Universal Traveller)

END OF MODULE VIII


Bureaucracies
CSA
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Education
Peers/
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Coalitions/
Networks of
CSAs
Welfare
Person/
Family
Network
Interest
Groups
Corrections
CSA
Recreation
Associations
CSA
Government
CSA

Interorganizational Networks

CSA = community service agency

MAKE A NETWORK

1. List 6 possible members of a network to assist in achieving your program goals.

    1. ______________________________
    2. ______________________________
    3. ______________________________
    4. ______________________________
    5. ______________________________
    6. ______________________________

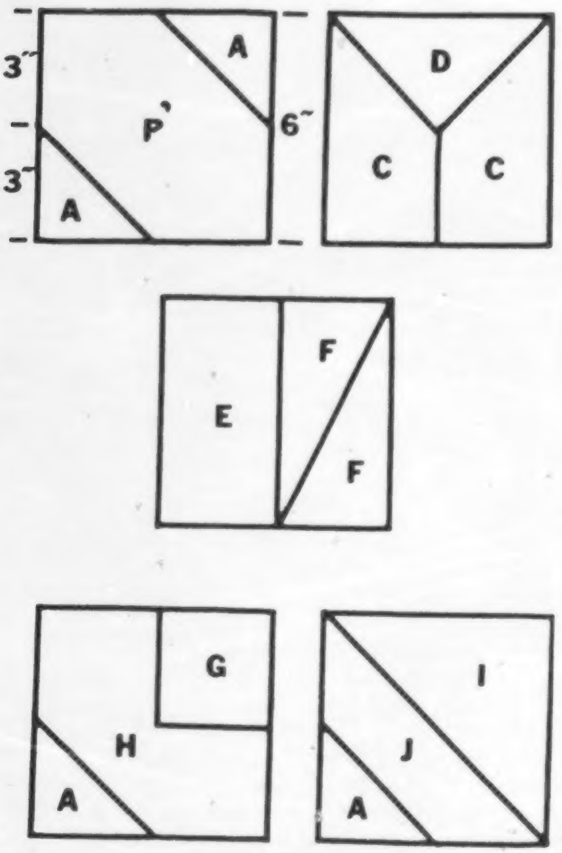
2. Draw a diagram of how you think the elements of your network might cooperate.

MODULE VIII: NETWORKING AND RESOURCE BUILDING--2 **WORKSHEET**

PLUSES AND WISHES

WHAT I HAVE	WHAT I WANT
WHAT MY ORGANIZATION HAS	WHAT I'D LIKE MY ORGANIZATION TO HAVE
WHAT MY COMMUNITY HAS	WHAT I'D LIKE MY COMMUNITY TO HAVE

BROKEN SQUARES GAME
MATERIALS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MODULE IX

MODULE IX: PREVENTING BURNOUT **TIME:** 3 HOURS

GOALS

- Make participants aware of the role burnout may play in their efforts to develop community-based prevention programs
- Enable them to develop realistic alternative coping strategies.

OBJECTIVES

At the end of this module, participants will be able to:

- Identify at least five symptoms of burnout
- Identify at least five causal factors in their own work/life that might lead to burnout
- Identify at least four possible strategies which that might employ to either prevent or alleviate burnout at both a personal and organization level.

MATERIALS

- Newsprint
- Magic Markers
- Pencils
- Post-test
- Opinionnaire

MODULE IX OVERVIEW

EXERCISE	TIME	METHODOLOGY
1. INTRODUCTION	5 MINUTES	LECTURE
2. IDENTIFYING SYMPTOMS AND CAUSES OF BURNOUT	30 MINUTES	LARGE-GROUP EXERCISE
3. COPING STRATEGIES	15 MINUTES	DISCUSSION
4. WRAP-UP AND REFRESHER	30 MINUTES	DISCUSSION
5. POST-TEST	30 MINUTES	INDIVIDUAL

MODULE IX: PREVENTING BURNOUT

TIME, MEDIA, AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
5 MINUTES	1. INTRODUCTION • "Burnout" is becoming a catchword throughout the human services. This concept involves looking at attrition rates, stress and anxiety problems, and frustration levels of people who are actively engaged in working with other human beings with personal, emotional, or psychic distress.
30 MINUTES Newsprint Magic Markers	2. EXERCISE: IDENTIFYING SYMPTOMS AND CAUSES OF BURNOUT • Trainer asks the participants to brainstorm symptoms of burnout: What does someone who's "burned-out" look like? How do they behave? An optional approach is to ask small groups to each draw a cartoon of a "burned-out" preventor. • On newsprint, trainer lists these symptoms, encouraging discussion as the exercise progresses. • Next, trainer asks participants to develop a similar list of causes: What causes people to burn out? Where do the sources of stress come from? What are the differences between burnout and fatigue?
15 MINUTES	3. DISCUSSION: COPING STRATEGIES • Trainer asks participants to generate possible sources of relief from these symptoms or ways to prevent burnout from occurring (COPING STRATEGIES). The three colums on the newsprint thus become: SYMPTOMS CAUSES COPING STRATEGIES Script: One way of looking at the options for formulating strategies for coping with burnout involves the concepts of "high-level wellness," as advocated by Dr. Donald Ardell. He discusses wellness, as opposed to disease, as having five major components:

MODULE IX: PREVENTING BURNOUT

TIME, MEDIA, AND MATERIALS	*OUTLINE OF TRAINING ACTIVITIES*
	1. Self-responsibility 2. Nutritional awareness 3. Stress management 4. Physical fitness 5. Environmental sensitivity a. Personal b. Social c. Physical - Trainer introduces these five concepts, and relates the coping strategies brainstormed by participants to these general categories. Discussion: Does Ardell's classification suggest any additional strategies for coping with burnout? Add new ideas to the newsprint list.
30 MINUTES	4. DISCUSSION: WRAP-UP AND REFRESHER - Individual writing: trainer asks individuals to list three things they learned during the training that they intend to use in their own communities. - Large-group discussion: the trainer asks each inividual to share one thing they intend to try with the large group.
15 MINUTES	- From that discussion, the trainer reviews the content and skills of the training experience, focusing on the practical materials and skills developed and/or practiced during the training.
30 MINUTES	5. POST-TEST - Trainer administers the post-test.

TIME, MEDIA, AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
	- After collecting the post-test, trainer allows opportunity for any discussion or reaction to the tests or the training.
	END OF MODULE IX

COMMUNITY-BASED PREVENTION SPECIALIST

Pre/Post-Test

Instructions: You have approximately 30 minutes to complete this assessment. Please read all questions carefully. So that learning gain can be measured from the beginning of the course to the end, please put your name on the assessment form.

NAME: ______________________________

AGENCY: ______________________________

TITLE: ______________________________

COMMUNITY-BASED PREVENTION SPECIALIST

Instructions: The following are true/false questions. Record your answer by circling the letter representing your response. Circle T for true, F for false.

1. T F Formal communication networks include key people, highly visable people, groups, and agencies within the community which can be used to disseminate information regarding drug abuse prevention activities and programs.

2. T F Burnout refers to the rate of attrition among people who are actively engaged in working with other human beings with personal, emotional, or psychic distress.

3. T F The concept of prevention was first developed in the field of preventive medicine.

4. T F As part of the prevention planning process, problem statements are generated as a result of determining the philosophy of prevention, determining the role of the SSA, analyzing legal mandates, and a survey of problem behavior indicators.

5. T F Pharmaceutical psychoactive drugs are more commonly used than black-market substances.

6. T F Primary prevention activities are directed toward those who have not had a problem with their drug use and those who have had a chemical use problem but have never been deemed appropriate for chemical dependence treatment.

7. T F Factual information on drugs deters and prevents drug use abuse.

8. T F Action planning serves to provide a framework for effecting change in a program's structure, process, and/or function.

9. T F It is important to plan for evaluation of your prevention program once it has become operational.

10. T F The Prevention Planning Model begins with an assessment of needs, includes the analysis of resources needed for tasks, and culminates with a determination of plan feasibility.

11. T F Primary prevention can increase the probability of early identification of various drug problems.

12. T F Although every community should provide education, it need not provide acculturation for its newcomers (e.g., children, immigrants).

13. T F Functional areas of a community include home, school, church, roadways, and parks.

14. T F Classifying drugs as "legal" and "illegal" has contributed to effective social and political drug policies.

15. T F To be effective in minimizing drug use problems, prevention programs need to address existing community societal problems.

16. T F Psychoactive drugs change the minds or moods of people who take them.

17. T F Few communities plan at the outset for the variety of social and health service programs that are needed.

18. T F Building community support is the primary factor for realizing prevention program objectives.

19. T F Psychoactive drug use was accelerated when chemists began to create synthetic substances.

20. T F In preparing a prevention program objective, the planner should consider whether the objective is consistent with organizational goals and whether the outcome of the objective is worth the time and effort required to achieve it.

Instructions: The following are multiple-choice items. For each item, circle the letter representing the best answer.

21. According to Klein, which of the following is NOT a function of a community?

    1. Providing sanitary waste disposal for its members.

    2. Creating and enforcing rules and standards of belief and behavior.

    3. Transmitting information, ideas, and beliefs.

    4. Making available the means for distribution of necessary goods and services.

22. NIDA's drug abuse prevention activities include which of the following models?

    1. Alternatives to drug use.

    2. Education programs.

    3. Media-based information/education campaigns.

    4. Intervention programs.

        a. 1, 2, and 4
        b. 1, 2, and 3
        c. 1 only
        d. all of the above

23. Which statement is NOT a reason why prevention efforts were initiated.

   1. Reduce demand for drugs.
   2. Reduce costs associated with drug abuse.
   3. Reduce drug usage by white middle-class youth.
   4. Reduce supply of drugs.

24. Which of the following is NOT a revolution which gave rise to acceptable drug-taking behavior?

   1. Taking drugs to alter the body for our convenience and pleasure.
   2. Taking drugs to cure the body of addictive dependencies.
   3. Taking drugs to cure diseases of the body.
   4. Taking drugs to cure diseases of the mind.

25. Which of the following represents the principal target group for prevention efforts?

   1. Social/recreational users.
   2. Non-users.
   3. Experimenters.
   4. Circumstantial users.

      a. 1, 3, and 4
      b. 1, 2, and 3
      c. 1, 2, and 4
      d. 1, 2, 3 and 4

26. The "high-risk" individual shows significant inadequacies in which of the following areas?

   1. Identification with viable role models.
   2. Intra-personal skills
   3. Inter-personal skills
   4. Religious values

      a. 1, 3, and 4
      b. 2, 2, and 3
      c. 1, 2, and 4
      d. 2, 3, and 4
      e. all of the above

27. In multicultural prevention planning, which of the following are important components?

1. Space relations

2. Racial/ethnic/cultural identification

3. Norms

4. Socio-economic status

a. 1, 2, and 3
b. 2 and 4
c. 1, 3, and 4
d. 2 and 3
e. all of the above

28. Types of networks include which of the following?

1. Peer Network

2. Person-family Network

3. Organizational Network

4. Human Service Networks

5. Interorganizational Networks

a. 1, 2, and 3
b. 3 and 5
c. 2, 3, 4 and 5
d. 2 and 4
e. all of the above

29. Which of the following statements are true when referring to how a community might react to change?

1. Resistence to change increases in proportion to the degree in which it is perceived as a threat.

2. Resistence to change decreases when it is perceived as being favored by trusted others, such as high-prestige figures.

3. Commitment to change increases when those involved have the opportunity to participate in the decision to make the change and its implementation.

4. Resistence to change decreases when the change is sudden and brought about by the use of direct pressure.

a. 1 and 2 only
b. 2 and 3 only
c. 1, 3 and 4
d. 1, 2 and 3

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